Maternal and Child Health Services
Title V Block Grant

State Narrative for Vermont

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The required assurances and certifications are maintained on file in the Vermont Department of Health's central administrative offices. The information can be accessed by contacting Sally Kerschner, Vermont Department of Health, Division of Maternal and Child Health, 108 Cherry St, Burlington, VT. 05401, 802-652-4179.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Ongoing public input for Title V programs takes a variety of forms that allows direct Title V input and also input into general MCH programs of the VDH. The public budget process is one opportunity, as the VDH budget is publicly available (on request and via publications on the website.) An annual legislative committee session is purposely advertised for public attendance to allow for input into Title V and other federal grant applications. Focus groups and surveys for the WIC and EPSDT programs are conducted to assess satisfaction with services and to solicit input for suggested improvements as well as additional services. The Office of Dental Health has conducted focus groups with low income consumers about access, satisfaction and awareness of oral health care services. The VDH/VCHIP Program for Opiod-exposed Newborns uses mothers who have experienced addiction as advisors for their program. The ECCS/Building Bright Futures planning processes both statewide and regionally have included parents of young children on the planning committees. The VDH Newborn Screening Advisory Committee has several parents of children with metabolic conditions as members. CSHN partners with parents (including parents of CSHCN who are not served or are not eligible for CSHN programs) through Vermont Family Network and its facilitated focus groups, surveys and interviews. The CSHCN Family Advisory Council is composed of parents. In addition, several CSHN staff members are parents of CSHCN. Title V grant application is reviewed annually by several VDH partners and the comments have been incorporated into the grant narrative and are considered for improvement in case management and clinical services. In Vermont, the VDH Title V partners comprise a large group of state and community leaders who advise and collaborate regularly on MCH public health and service delivery issues. These partners participated in five year needs assessment process and are regular members of VDH advisory committees and collaborative efforts (School Health, Birth Registry, Early Childhood Comprehensive Systems, Department of Children and Families, Newborn Screening, Comprehensive Integrated Services, Department of Mental Health, etc) See attached Public Input Table, individual program descriptions, and Sec 111E for further information. In addition, current efforts are underway for the Agency of Human Services to improve communication between external stakeholders (e.g. Vermont Family Network, Vermont

Federation for Families, American Academy of Pediatrics -- Vermont Chapter, Vermont Academy of Family Physicians, and various early childhood service providers) and the Agency's departments and offices involved with the integration of services for children generally referred to Children's Integrated Services (CIS). Continued stakeholder involvement with CIS will be encouraged. The leadership of Vermont Family Network has provided specific content, data, and editorial guidance to this year's document. The Title V coordinator has begun to attend quarterly meetings of the District Office MCH Coordinators to hear updates on Title V services and community organization needs for the MCH population. IN 2010, fiscal restructuring passed by the VT legislature and called Challenges for Change has initiated a period of rapid planning and structural redesign of services for children and families, including MCH services. The AHS leadership consistently invites large numbers of stakeholders and "consumers" to provide input. Most recently the invitation has gone out to have input into the redesign of "Enhanced Family Services."

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The overall guidance for the Title V Strengths and Needs Assessment was provided by the MCH Leadership Team with representation from Local Health Services, EPSDT, WIC, School Health, Family Planning, Injury Prevention, and Title V. Dr. Breena Holmes, MCH Director, provided leadership for the SNA process and will work with the Leadership Team to provide follow up for the issues identified in this assessment and also planning for addressing the Ten Priority Goals. Examples of participating partners within state government are the Department for Children and Families, Medicaid, the Department of Mental Health, and the Department of Education. Community and statewide groups are numerous and include such organizations as VCHIP, University of Vermont, Fletcher Allen Health Care and community based birth hospitals, the Farm Health Task Force, the Child Fatality Review Team, the Domestic Violence Fatality Review Team, Parent Child Centers, Community Health Clinics, Home Health Agencies, Prevent Child Abuse Vermont, Vermont Chapters of AAP and AAFP, Planned Parenthood of Northern New England, Safe Kids Vermont, and Vermont Family Network.

The MCH strength and needs assessment will inform several planning efforts at VDH and also will be useful to VDH partners both in state government and in non-state and local community organizations. For example, VDH is preparing the 2010 Injury Prevention Plan - action steps in this plan will reflect population injury prevention issues as detailed in the Title V assessment. In addition, several 2010 Affordable Care Act grant applications are presently being prepared and will use the findings of the Title V assessment for program planning and serving special populations. The assessment will provide information on program, staff, and other organizational capacity which will be useful to these grant planning efforts in addition to over all strategic planning for
both MCH and other VDH departments. Capacity for action will be determined by such factors as the information contained in this assessment, existing programs and their funding and effectiveness, programs and initiatives managed by other stakeholders (so as to complement efforts and not duplicate) and an examination of emerging health issues.

The MCH Leadership Team considered input from all stakeholders when reviewing the list of potential priority goals. The Leadership Team chose to continue with the 10 Priority Goals as used in the 2005 TV SNA. The Team felt that these Goals are still applicable to Vermont in 2010 and chose to continue using this list for MCH planning into the next five years. The goals are broadly worded and reflect the vision of a healthy MCH population for Vermont. In addition, they allow flexibility for planning within each goals. These goals were first created in 2002 via a goal-setting process facilitated by the planning unit of the Vermont Agency of Human Services. At that time, VDH began using the concept of goal setting and asset promotion for Title V planning. These goals continue to be useful for Vermont state government. For example, they are included in the recent Challenge for Change state legislation that was created to streamline systems in state government. Use of these goals when streamlining programs to decrease program "silos" will be useful to maintain overall goals for both AHS, our partners at DCF and Mental Health, and also for MCH planning.

The measures are worded to reflect a combination of both the traditional approach of program evaluation or "deficit" wording and also the newer approach of strengths-based wording.

Measures were chosen to reflect the existing work of VDH programs or to begin measurement of initiatives that are in the beginning stages of implementation. It was desirable to include measures that reflected the broad scope of MCH public health -- hence the array of VDH programs such as environmental, CSHCN, exercise and the built community, etc. Six measures were determined to be still relevant and are continued into the next five years planning period. A new measure, that of using YRBS data to assess the percent of youth who wear bicycle helmets, was added. This measure has a focus on injury prevention, safe communities, and physical activity promotion. In the coming year, the MCH Leadership Team will consider three additional measure dealing with: 1) measurement of CSHN access to a medical home, 2) a measure from the ACA funded home visiting program assessing families that are stable and support children, and 3) measurement of developmental screening practices by primary care clinicians to address the issues around emotionally healthy children.

III. State Overview
A. Overview

A. OVERVIEW (See also Sections III B, III D, IV A, IV B)

Vermont is a scenic and mountainous state, located in New England, sharing its northern border with Quebec, Canada. It is a rural state with the 2009 revised census showing a population of 621,760. Chittenden County has the largest population concentration with about 150,000 residents, almost ¼ of the state's population. Burlington, in Chittenden County, is the core of the state's only Metropolitan Statistical Area, which extends into parts of Franklin and Grand Isle Counties. Addison County also has strong connections to the MSA. The fringes of this region still have strong ties to Vermont's agricultural industry, which sometimes causes conflict over land use planning and policies. The estimated population of this MSA is 166,126, representing approximately 27% of the state's population. Of the 255 towns and cities in Vermont, nine have total populations that exceed 10,000. These nine sites account for 25.2% of the state's population. Vermont has 14 counties.

In 1990, Vermont's racial and ethnic minority populations were estimated to be about 2% of the total population. By 2007, that figure had doubled to 4%, representing about 24,000 Vermonters. While these numbers are still proportionately small compared to the rest of the US, Vermont racial and ethnic populations are growing at a much faster rate than the population overall. Between 1990 and 2007, Blacks/African Americans have been the fastest growing population in Vermont, with their numbers more than tripling in the past 18 years. The second fastest growing racial group in Vermont is Asians/Native Hawaiian/Pacific Islanders -- with populations increasing from 0.5% of the total population in 1009 to 1.2 % in 2007.

Aging of Vermont's population is similar to the changes nationally, the median age for Vermont was 39.3 years in 2003, compared to a national median of 35.9 years. From 2000 to 2003, there was a significant increase in the proportion of the population aged 55-64, as the "baby boom" generation ages. The fastest growing segment is the 45-64 year olds and there has been a slight decline since 2000 in the under 15 and in the 30-39 age groups. A declining birth rate is now considered a main reason for the decrease in school enrollment: 1995 enrollment of 98,361; 2006 enrollment of 96,363.

Household composition is changing - the number of Vermonters living alone increased by 28% in the past decade, to 63,112. There is an increase in the number of unmarried partners living together -- 18,079 (47%). The number of households with married couples living together fell to 52.5% of all Vermont households. Married couples with children younger than 18 (the traditional nuclear family) make up 23.2% of the households in Vermont. On July 1, 2000, a new Vermont law went into effect granting same-sex couples in Vermont all the benefits, protections, and responsibilities under law as are granted to spouses in a marriage. In addition, the marriage equality act, effective September 1st, 2009 which allows same-sex couples to marry in Vermont, discontinued the need for the separate status of "civil unions".

Vermont's governmental structure consists of state government and town/city government, with essentially no county governmental structures, except for certain key services such as the court system. The bicameral legislature is considered a citizen legislature that is in session during January through May each year. Vermont has no county health departments, but is divided into 12 Agency of Human Services districts, each with a district office of the Vermont Department of Health headed by a District Director (Vermont's equivalent to a local health official). The 2005 government reorganization created regional field offices of the state's human services offices, with which the VDH offices collaborate closely.

Vermont is the home to many long established businesses such as IBM and C&S wholesalers,

but the economy is diversified with industries in manufacturing, tourism, small businesses, and services. Agriculture is still a vital part of the economy, but its prevalence has diminished over the past several decades. Vermont's rural nature and areas of poverty presents the issue of sparse populations having ready access to resources and services. Residents living in isolated areas of the state may have special difficulties accessing services and medical care (particularly in the harsh winter months) due to their remote locations and the less than optimal road conditions.

A sizeable proportion of Vermonters are living either in poverty or are living very near the poverty level. In Vermont, for 2005-2007, the median income per person was $26,223 and the median household income was $49,382. For these same years, 7% of all families and 13% of families with children under age 5 reported their past year's income to be below the poverty level. Also, 40% of families with a single mother and children under age 5 reported their income to be below poverty level. In Vermont, low income people are more likely to be young (18-34,) less educated, unemployed or unable to work, female, or of an ethnic/racial minority. Vermont's minimum wage is $8.06/hour ($15,974/year,) which is higher than the federal minimum ($7.25/hr) but still much lower than a livable wage ($27,188/year.) As of June, 2010, the state's unemployment rate is 6.2$.

In 2008, 7.6% or about 47,000 Vermonters were uninsured, a significant decrease from 2005, when 9.8% or about 61,000 were uninsured. In 2008, 22% or 18-24 year olds were uninsured, the highest percentage of any age group. For children under age 18, 2.9% have no insurance, the lowest percentage of any age group. For all Vermonters, 60% have private insurance as their primary coverage, while 14% are covered by Medicare and 2.4% by military plans. For those enrolled in publicly funded health insurance programs, coverage can be precarious - in an average month, up to 70% of CSHCN lose Medicaid coverage at least temporarily. In 2008, 12% of Vermonters (app 55,000) did not have a specific source of primary health care, compared to 20% us. The highest percentage of Vermonters with no medical home are among those younger than 35, those earning less than 250% of poverty level, and those with a HS diploma or less. Chittenden County, home to the state's largest medical facility, has the highest ratio of FTE primary care physicians at 94.4/100,000, compared to Grand Isle at 14.9. Similar disparities are found with dental care, with Chittenden County having 83 of Vermont's 282 primary care dentists.

Vermont ranks 1st nationally in the ratio of students to teachers in the public schools: 11.7 pupils to one teacher vs. a national ratio of 15.9. Nearly 90% of Vermont adults have a high school education or more, compared to 84% nationally and 33% hold a bachelor's or more, compared to 27% US.

Since 1980, the Refugee Resettlement Program has relocated well over 5,000 refugees to Vermont, increasing the cultural and linguistic diversity of the population being served by the health care and social service system of the state. Initially, resettled refugees arrived primarily from Vietnam, Cambodia, and the Balkans; more recently refugees are from sub-Saharan Africa. The health needs of migrant farm workers are becoming evident as this population is rapidly growing in Vermont. Estimates show there are about 2,500 migrant farm workers with concentrations in Franklin, Grand Isle, and Addison Counties.

Vermont Health Care System of Publicly Funded Insurance:
In July, 1995, Vermont's Medicaid 1115 Research and Demonstration Waiver application to create and implement the Vermont Health Access Plan (VHAP) was approved. The waiver allowed for a basic package of insurance coverage for previously uninsured adults with incomes up to 150 percent of the federal poverty level (FPL). In February, 1999, eligibility for previously uninsured adults was expanded to include parents and caretaker relatives of Medicaid-eligible children up to 185% FPL. In October 1998, the children's Medicaid program, Dr. Dynasaur, expanded eligibility for children birth to 18 years to include those with incomes up to 300% FPL, further reducing the percentage of Vermont children who are uninsured. (Vermont had been covering children with incomes up to 225% FPL since the early 1990's.)

In the Fall 2005, Vermont secured approval for Section 1115 Medicaid waiver, the "Global Commitment waiver," that allows Vermont to fundamentally restructure its Medicaid program. The waiver imposes a cap on the amount of federal Medicaid funding available to Vermont for nearly all Medicaid expenditures except for SCHIP and Nursing Homes. It also includes all Medicaid administrative expenses. In combination with a second, long-term care waiver, the Global Commitment waiver makes Vermont the first state in the nation agreeing to a fixed dollar limit on the amount of federal funding available for its Medicaid program. In exchange for taking on the risk of operating under a capped funding arrangement, the waiver allows Vermont to use federal Medicaid funds to refinance a broad array of its own, non-Medicaid health programs, and a greater level of program flexibility. Such flexibility includes changes in cost sharing, plan design, and possible caps on enrollment for "non-mandatory" Medicaid beneficiaries. Global Commitment's stated goals are to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes. Also cited are state fiscal problems and the desire for more flexibility to change the Medicaid program without federal review. There are 4 key elements: 1) Imposes a global cap that limits the state to drawing down federal Medicaid matching funds on no more than a total of $4.7 billion in Medicaid spending for acute care services over a 5 year period. If, however, Vermont reaches the $4.7 billion cap, it will not receive any additional assistance from the federal government for Medicaid costs. This is a marked contrast to the regular Medicaid financing structure, which provides states with guaranteed federal matching Medicaid funds for all Medicaid services provided to Medicaid beneficiaries with no set limits. 2) Allows the state to establish itself as a managed care company -- allowing Vermont to pay itself a premium for each beneficiary that it serves. If the state can deliver care for less than the premium revenue, it can use the "excess" revenue for a broad array of purposes. Within limits, the state controls the amount it pays itself, which means it can ensure that "excess" premium revenue arises by paying (with the assistance of matching federal funds) more than needed to operate its Medicaid program. 3) Provides new flexibility to use federal Medicaid funds for non-Medicaid health programs. Through the "excess" premium revenue, Vermont can replace some of its own spending on various state-funded health care initiatives. Some 50 initiatives have been identified, such as tobacco cessation, domestic violence, and the state's medical school and public laboratory. Estimates are that Vermont may be able to secure up to $335 million in new federal Medicaid matching funds under the waiver that it does not need to use in providing care to Medicaid beneficiaries. Instead, it can use the "extra" federal funds for fiscal relief or to expand non-Medicaid health initiatives. 4) New flexibility to reduce benefits, increase cost-sharing, and limit enrollment or set up waiting lists for most of the "optional" and "expansion" populations (groups that the state covers at its option with the assistance of federal Medicaid funds.) These populations include many children and parents in low-income working families and all other adults who are not disabled or elderly covered by the Vermont Medicaid program. Under the Global Commitment waiver, the federal government has given the state significant authority to decide if and when it will impose reductions or cost sharing increases. In the Spring, 2008 new regulations adds many significant elements to original Health Care Reform legislation. Examples: requires inventories of school nutrition and physical activity programs with recommendations on how to improve and build on these programs and how to organize grant funding for future programs based on best practices, updates on recommendations for nutritious foods available in schools and school nutrition policies, review of best practices in primary care settings for treatment and prevention of overweight in children and recommendations for insurance policies that reimburse those practices, review of practices to encourage the availability of healthy foods (esp local foods) to communities, review of best policy practices encouraging worksite wellness. In development of these reviews and recommendations, much coordination will be required between public/private health groups such as insurers, Medicaid, VDH, Depts of Education, Agriculture, and the Banking, Insurance, Securities, and Health Care Administration. In 2010, Vermont legislature passed S.88 intended to develop health care options giving universal access to care, one option being a single payer system.

Vermont Family Network (formed through merger of Parent to Parent and VT Parent Information

Center) reports about 1200 contacts with families per year. VFN gathers insurance information (voluntary) from parents. In this most recent year, quarterly summaries showed between 61% and 79% of families reporting that their child had Medicaid coverage, either alone or in combination with commercial insurance. Commercial insurance alone varied between 13% and 21%. Not all families were willing to report their coverage.

The MCH Director, the CSHN Medical Director, and other key MCH staff continue to be involved in the administration of the Medicaid program. For example, through EPSDT, the MCH Director, the Director of the Office of Local Health, and other key program managers continue to assure that children and youth have access to quality health care through the dissemination and updating of the Vermont-specific pediatric periodicity schedule and the provider toolkit that accompanies it. The VDH managers work very effectively and collaboratively with Vermont American Academy of Pediatrics and American Academy of Family Physicians to continuously review, develop, and distribute best practices for pediatric care. Also, the EPSDT program has enhanced its system of regular contact with Medicaid families to inform them of their child's health needs within the pediatric periodicity schedule. In 2008, recommendations for best practice were updated to reflect the revised Bright Futures, Guidelines for Health Supervision. Regional meetings were held throughout Vermont, bringing together the regional Building Bright Futures leadership, AAP/AAFP, primary care providers, community-based providers of home health and early intervention, Community Public Health, the MCH director and CSHN medical director, to present the new AAP Bright Futures guidelines and to promote PCP participation in their regions' BBF planning. The goal is to promote evidenced based standardization for pediatric screening. In addition, a Vermont --specific oral Health periodicity schedule is being developed in accordance with the recommendations of the America Academy of Pediatric Dentists. As of Jan 2009, OVHA is allowing providers to bill for the well child visit and the developmental screening on the same day when a standardized screening instrument is used. Any standardized screening instrument in AAP policy statement is accepted. Providers must document the screening and the instrument used in the patient record. VDH/OVHA working with VCHIP to promote full implementation. VHCIP will assess current practices and develop a "preferred" list of AAP standard screening instruments and work with providers to implement. Also, DCF working with CIS teams to implement referral, intake, triage system to assist families in accessing services to promote healthy development. Although Medicaid allows PCPs to bill for developmental screening in addition to the well child visit, the provider agreements which many PCPs have with commercial insurers pose a barrier to billing Medicaid, since commercially insured patients must also be billed and their insurance often does not cover the separate screening charge.

In Vermont, individuals with disability-based SSI are also eligible for Medicaid. A study group examined strategies for enrolling SSI recipients in the managed care plans. After a brief pilot in two counties, it was determined that the best form of managed care for these individuals would not be a pre-paid HMO model, but rather a primary care/case management model (PCCM). This PCCM program, called Primary Care (PC) Plus, began in October, 1999. However, the impact of prospective, monthly premiums on enrollments for Dr. Dynasaur continues to be of some concern. Medicaid tracks the disenrollments, and the CSHN program monitors the Medicaid disenrollment of CSHN clients monthly and notifies CSHN staff. In FY 2008 however, the Dr. Dynasaur premiums were reduced by half and then to rise again in SFY09; CSHN efforts to help families maintain continuity of coverage will need to intensify. CSHN continues to meet with Medicaid leadership to understand and improve collaboration with the new Medicaid case management initiatives, which, although targeted to adults with certain chronic conditions, do include some CYSHCN, especially those with respiratory illnesses. A significant percentage of CSHN have both private and Medicaid insurance. CSHN noting difficulties in coordination of benefits when families have both public/private insurance, leading families to drop private coverage. CSHN SIG includes focus on health care financing analysis to help understand and advocate for policy improvements. CSHN has successfully blended its accounts payable process with that used by Medicaid and Part C. A single fiscal contractor (HP, formerly EDS) enrolls all providers, applies established fee agreements, sequences payers, and processes payments. In addition, CSHN and Medicaid have aligned their determination of medical necessity. CSHN's and

Medicaid's physical therapist consultants work side by side to review authorization requests, to achieve a consistency irrespective of health care coverage.

The Child Health Insurance Program (Title XXI)
Children who have another form of insurance are not eligible for CHIP, but continue to be eligible for the expanded Medicaid/Dr. Dynasaur program described above. These under-insured children are enrolled with Medicaid as a secondary payer of last resort, after insurance (or commercial HMO), on a fee-for-service basis. Vermont is engaging in strategies to promote enrollment and utilization in these expanded insurance opportunities for children, such as conducting an oral health public education campaign and sending informing letters to families who use Medicaid. The FFY 2004 Vermont state budget included a provision to implement a premium assistance program for SCHIP beneficiaries whose families have access to employer sponsored insurance. Prior to implementation, the commissioner must report to legislative committees regarding the cost-effectiveness of the initiative, including the cost of administering the program compared to potential savings. Vermont's comprehensive health care programs for children can offer nearly universal coverage for families. In the state legislative session of 2005, more efforts were made to expand coverage to a universal, state funded system of health care. The proposed legislation did not pass, but a legislative committee was created to examine possible solution for Vermont in the financing of universal coverage for its citizens. In May, 2006, the legislature and the governor agreed on a compromise bill to establish increased health care coverage by establishing premium assistance to low income Vermonters that will allow them to purchase the newly created Catamount Health or an employer sponsored health insurance. By October 1, 2007, the Catamount Health Plan was be available to Vermonters who are not currently eligible for the state's other funded programs. Catamount will offer Vermonters the choice of private health plans, which offer basic and uniform benefit packages. In certain circumstances, some Vermonters may be eligible for premium assistance. In addition, Vermont is proceeding with a plan to require those adults on state insurance programs who currently are offered health insurance but do not take it to take their employers option. The state will make a benefit analysis to determine if it is more cost effective to assist the individual with premium assistance and move them off state rolls or to keep them on the state insurance.

Current Priorities:
The Vermont Blueprint for Health is a vision, a plan and a statewide partnership to improve health and the health care system for Vermonters. The Blueprint provides the information, tools and support that Vermonters with chronic conditions need to manage their own health -- and that doctors need to keep their patients healthy.The Blueprint is working to change health care to a system focused on preventing illness and complications, rather than reacting to health emergencies. The Blueprint is based on the Chronic Care Model. The goals are 1) To implement a statewide system of care that enables Vermonters with, and at risk of, chronic disease to lead healthier lives. 2) To develop a system of care that is financially sustainable, and 3) To forge a public-private partnership to develop and sustain the new system of care. The Model envisions an informed activated patient interacting with a prepared, proactive practice team, resulting in high quality encounters and improved health outcomes. Six components: community, health system, decision support, delivery system design, self management education and clinical information systems. Intense planning for implementing the Blue print began in 2004 and in 2007 state legislation was passed to codify Blueprint as part of health care reform and enable its provisions to be in line with the Medicaid Global Commitment. Pilot areas are working on specific aspects of Blueprint such as hospital systems, quality improvement, community care coordination, and electronic medical information systems. There are plans to coordinate BP with other Agency programs such as mental health services, elderly services, etc. In addition, planning for coordination BP concepts with pediatric medical home is taking place.

In 2008, Vermont has been awarded a CSHCN State Improvement Grant which will support an inclusive, comprehensive process for examining needs, refocusing priorities, and, above all, integrating the several complementary and overlapping redesign efforts for children and families being undertaken by the Agency of Human Services--in effect, integrating the integration. Two of

these efforts--the blending of three early childhood programs (Part C, Healthy Babies, and Early Childhood Mental Health--now called Children's Integrated Services), and a new initiative to redesign services for children with disabilities, headed by the MCH director and a special assistant to the AHS Secretary--have particular affinity for CSHN redesign. The overarching goal of the initiative is to transform the existing system of care for CYSHCN into one that: serves the true population of CYSHCN, assures services that reflects evidenced based and culturally effective practice, supports delivery system in which primary care services, including early and continuous developmental screening, are provided in accordance with Bright Futures 3rd edition in medical homes with appropriate and effective linkages to the system of specially care, assures best opportunities for access to adequate health care financing, operates within community based, coordinated, integrated systems of care, supports youth as they transition to adulthood. VDH will address all 6 MCHB outcomes, focusing on developmental screening/medical home, health insurance/finance, community integrated services. The theme of family/professional partnerships/cultural competency is infused throughout the vision and grant action plan. In August, 2009, CSHN NFI grant coordinator resigned and a vacancy in the MCH director position complicated the timely recruitment for a new coordinator. As of July, 2010, we are poised to finalize an offer to a new candidate. Importantly, however, we have made remarkable progress on NFI goals, boosted in part by the momentum of AHS reorganization (NFI fiscal goals; the need to clarify CSHN roles in a redesigned AHS system), and by internal drive for practice improvements within the largest CSHN program, Child Development Clinic, in anticipation of an influx of referrals resulting from improved early screening.

In 2010, CSHN spearheaded action to obtain and deliver H1N1 vaccine to the most at risk children with chronic illnesses, in coordination with pediatric specialists and primary care.

Child Lead Poisoning Screening and Prevention: See Section IVB and SPM#10.

Initiatives for mental health needs of children and families: see Section IIIB and SPM #9.

Healthy Babies Kids and Families and ECCS: See Section IIIE and SPM#2.

VDH in coordination with providers, schools, insurers, and others, has developed a model Health Screening Recommendations for Children and Adolescents, also known as the Vermont Periodicity Schedule (historically funded by CISS grants.) Although the federal law requires that the VDH EPSDT program determine the scope of services for children using Medicaid, Vermont developed this well child screening instrument for all children, regardless of insurance payor. The Vermont EPSDT periodicity schedule has been important in the effort to promote new approaches to child and adolescent health supervision, consistent with the current emphasis on health promotion and the prevention of psychosocial morbidity. A clinical providers' tool kit has been developed which is available on-line at the VDH website -- intended for ready access during the clinical visit.

Concern about Vermont's teens high rates of marijuana and alcohol -- Center for Substance Abuse Prevention federal grant for research-based community programs to prevent alcohol and drug use among Vermont youth. In addition, a growing concern about the use of illegal drugs such as heroin and cocaine has focused new planning and community based efforts. In 2003, a methadone clinic opened at Fletcher Allen Health Care in collaboration with Howard Mental Health Services. Mobile methadone clinics were introduced in Newport and St Johnsbury in 2005. See SPM #3.

The VDH (MCH, Office of Local Health, Alcohol and Drug Abuse Programs) are responding to a growing maternal child health concern regarding high risk chemically addicted pregnant and parenting women. Identified women are referred to FAHC/UVM Comprehensive Obstetrical Service (COS) for prenatal care: screening, nutrition, referrals to substance abuse treatment, consultation with a neonatologist occurs at 28 weeks EGA. Efforts are being made to create collaboration for statewide system of care for mothers and children including mental health, child

welfare, birth hospitals, home health agencies, pediatric and obstetrical practices, corrections and substance abuse providers. VDH/Vermont Child Health Improvement Program (VCHIP) and Vt Regional Perinatal Health Project coordinate with birth hospitals on transport procedures and protocols for opioid exposed mothers and newborns. Systems approach being developed to coordinate between all community and regional groups involved in treatment of addicted/recovering mother and opioid exposed infant.

New initiatives are being planned to not only combat obesity and promote physical fitness in all ages, but also to increase food security for children and their families. In 2003, Vermont's governor requested the Department of Education and VDH collaborate in strategies to counteract the problem of increasing incidence of overweight children and youth, resulting in the Fit and Healthy Kids initiative. Key strategies for implementation and funding for staff were allocated in the SFY05 budget. Funding will also increase the number of Run Girl Run sites to 23, serving over 450 girls (Run Girl Run is a year round program designed to give middle school girls the information, training, confidence and support to make healthy lifestyle choices) and expand the Fit WIC program to include non-WIC families. (Fit WIC encourages physical activity in preschool children by providing parents and child care providers with age-appropriate games and activities designed to promote exercise.) In 2004, Vermont received CDC funding for the grant program, Nutrition and Physical Activity Programs for Prevention and Control of Obesity and Related Chronic Diseases. In 2005, the new Obesity Burden Document describes the issue of women of childbearing age who are overweight or obese and in 2007 the Fit and Healthy Vermonters Obesity Prevention program produced Vermont's Obesity Prevention Plan and Obesity and Health, an Obesity status report to assist in state and community planning. A statewide Advisory Committee is meeting regularly to coordinate action steps from the state's obesity Fit and Healthy Vermonters strategic planning document. Projects include: development of a resource guide for schools working to implement wellness policies guidelines as required by federal law, development of worksite wellness guidelines, and a toolkit for pediatric and primary care providers for the identification, assessment and treatment of overweight and obesity in children and adults. An executive order from the governor created a statewide Hunger Task Force to address issues of hunger and food insecurity. Produced the provider practice resource Promoting Healthier Weight in pediatrics and adult primary care uses a strength based approach to encourage youth and adults to set goals for behavior change. In coordination with the Blueprint community group physical activity and walking programs have been implemented in each of the 12 local health offices. In 2009/Vt received AAP 2010 grant designed to connect Vt-AAP members with schools/communities to integrate or incorporate best practices into the variety of obesity prevention/intervention projects now in place in Vermont communities. VDH and VCHIP have developed a practitioner toolkit "Promoting Healthier Weight in Pediatrics." The toolkit along with other program resources and tools developed can be found on the FHV website http://healthvermont.gov/fitandhealthy.aspx. FHV staff have worked closely with the Legislative Health Care reform commission to prepare background and recommendations as follow up from the 2009 Healthy Lifestyles component of H.887 the Health Care Reform bill. Farm to School grants increase locally produced foods to be used in school food service programs. See SPM #4/#6.

The Injury Prevention Program was established in 2000 with the hiring of a coordinator via CDC funding. The initial Injury Prevention Plan was released in 2002 and an updated version is being prepared for 2010. Examples of priority areas include motor vehicle crashes, interpersonal violence and child maltreatment, falls and hip fractures in the elderly, farm related injuries, off-road crashes, infant safe sleep, youth suicide prevention, concussion an sports related injury. The Program coordinates closely with MCH Planning, Office of Local Health, the Child Fatality Review Committee, Women' Health. Governor's Highway Safety Commission, Farm Health Task Force, and Safe Kids Vermont. A parent education pamphlet about infant safe-sleep environment has been created and distributed to medical practices and child care facilities. Close coordination with the Vermont Domestic Violence Fatality Commission sand the Vermont Network for Domestic and Sexual Violence Prevention. Annual Injury prevention symposiums are held on issues such as poisoning preventing, childhood injury prevention in rural Vermont, and agricultural safety. The

statewide Youth Suicide Prevention Coalition (funding from G. L. Smith grant) is providing statewide interventions such as gatekeeper trainings for school and community personnel and public awareness campaigns for parents and youth. Vermont has begun updating the Vermont State Injury Plan. Injury program exploring new focus on farm related injuries and also those injuries related to living in rural areas. The research and goal setting for these issues is being done in collaboration with Vt Farm Health Task Force, Children's Safety Network, and Vt Office of Primary Care/Rural Health. Also, new collaboration nationally and in New England between Offices of Rural Health, MCH/Title V, Child Death Review, and Injury Programs. Rape Prevention Education grant funded program from CDC is planning to distribute community funding via competitive bid that reflect evidenced informed strategies for rape and sexual violence primary prevention strategies. Act 1 passed by Vt legislature in January 2009 requires sexual violence prevention to be taught in the school comprehensive health education programs - RPE program and Sexual Violence Prevention Task Force developing suggested curriculum to be used in schools to meet this legislative mandate.

Women's health's programs focus on outreach, screening and lifestyle counseling via community health providers such as FQHC and Planned Parenthood of Northern New England. The Ladies First program works to improve access to preventative health screening services, including screenings for heart disease and breast/cervical cancer screening for low income/underinsured women 40-64 yrs of age.

In the Tobacco Control Work Plan (first issued June, 2001), the VDH put forth a ambitious plan with detailed strategies aimed at reducing smoking rates by half in all segments of Vermont's population. Particular attention is given to the high rate of smoking among pregnant women. Other programs focus on smoking prevention/cessation programs via employers, and programs focusing young men aged 18-24 years of age. Programs for youth continue via Vermont Kids Against Tobacco (middle school age) and Our Voices Exposed (high school age.)

Environmental health issues that are of special concern for children's health continue to be a focus of attention for assessment and planning.

Vermont receives CDC funding to upgrade state and local jurisdictions' preparedness for and response to bioterrrorism, other outbreaks of infectious disease, and other public health threats and emergencies. As a small state, there is a close relationship between VDH Central, the local offices, and other state and local agencies, professional and voluntary organizations, hospitals, and the National Guard. Vermont is also developing cross border collaborations with neighboring states and Canada.

In response to the threat of H1N1, over 202,000 H1N1 vaccinations have been administered statewide, with approximately 62 percent of pregnant women, 68 percent of household contacts with children under 6 months, 43 percent of health care workers and EMS staff, 55 percent of persons aged 6 months to 24 years, and 25 percent of persons with higher risk health conditions 25 to 64 years of age (all target groups) receiving the immunization. Furthermore, over 600 school and public vaccination clinics were successfully conducted.

Infant mortality reduction and improving birth outcomes continues to be a high priority for the Health Department. The infant mortality rate in Vermont for 2008 is 4.6/1,000 live births. Although a low rate, our MCH surveillance reports indicate that the rates overall, tend to not be significantly different year to year. However, surveillance continues to monitor these rates that, although low, may be slightly increasing and the two leading indicators related to infant mortality, low birthweight and preterm delivery, are increasing. These data will be monitored by the VDH in order to guide strategic interventions. VDH continues to focus on the prevention of preterm deliveries and identification of psychosocial risk factors that put women at risk for preterm delivery. In 2002, the legislatively mandated Birth Information Council (BIC) was formed under the direction of the Commissioner of Health. The broad based membership of the committee recommended the creation of a Birth Information System to enhance Vermont's ability to identify

and refer to services appropriate newborns with special medical conditions. Approval received by state legislature - CDC and state funding is being used to support the position of a Birth Information System Coordinator to implement the system. VDH grant to Vermont Child Health Improvement Program (VCHIP) for a variety of deliverables on improving birth outcomes, including training for neonatal health care providers, QI assistance for birth hospitals, and a web-based data registry (OBNet) collecting information on maternal-fetal risk factors, interventions and outcomes, IN addition, VDH has implemented a Folic Acid marketing campaign, and distributing multivitamins non-pregnant WIC clients.

VDH is working to improve health outcomes using the framework of social determinants and also the Lifecourse approach to public health interventions. Several trainings for VDH staff have been held on both approaches over the past several years, some trainings organized by the Boston University School of Public Health via MCHB grants. The recently released "Health Disparities of Vermonters" examines health disparities via the framework of social, educational, and economic parameters in addition to racial/ethnic status. This report is influencing VDH strategic planning and will also inform MCH strategic planning.

In 2002, VDH and the Department of Education received a CDC infrastructure and expanded school health coordination grant. At both the DOE and VDH there is a designated coordinator whose purpose is to work with community schools on the CDC coordinated school health model of coordinated school health services, programs, and policies in schools under the broad definition of school health. Each participating school or school district is encouraged to create a School Health Action Committee that plans individual school responses to the nine components of the School Health Model (such as enhancing clinical services, supporting healthy nutrition, promoting staff wellness, etc.) Goals of the program include increasing communication and collaboration between DOE and VDH on all levels, especially at the state planning level and within individual schools. The School Health Coordinating Council (DOE, VDH, School Principals' Association, Vermont School Boards' Association, and Vermont School Superintendents' Association) meets monthly to coordinate statewide health related activities and policies for school aged children. In 2009, VDH did not receive grant renewal for the Coordinated School Health Grant from CDC. Efforts were made to maintain the gains made during the 7 years of the grant-funded programs utilizing existing resources. A major success has been that the EPSDT school data system now allows for ready access to school nurse reporting on various elements from school nurse survey. For example, in the school year 2007-08, 80% of students reported having some sort of health insurance, 55% reported having a well child exam in the last year, and 62% reported being seen by a dentist for a dental checkup. In 2009, work with AAP, AAFP, School Nurse Association, Principals/Superintendents/School Boards Assns/VCHIP/DOE resulted in a plan for wellness exams designed to combine school-required school sports physical and traditional annual exams using Bright Futures standards. One result being that students needing a "sports physical" will receive compete BF wellness exam. Also, in 2009, VDH created a newly created position of state school nurse consultant: duties are to maintain/update school nurse standards of practice and provide TA to school nurses/VDH staff. In 2009, a newly signed MOU between VDH and DOE will jointly approve standards in School Nursed Standards of Practice Manual. Newly established Joint Committee to research and make recommendations to Commissioners on issues such as school nurse ratios, training, telemedicine, coordination with medical homes, etc. In 2009 an update to Vt Title 16 aligns school vision/hearing screening to AAP Bright Futures Guidelines, thus avoiding the duplicating of screening activities. In 2010, there are plans to create an on line new School Nurse Orientation program. This is a required component for DOE school Nurse certification. This course is a collaborative effort between VDH and DOE and will include clinical practice guidelines as well as program recommendations such as CDC's Coordinated School Health Model. The improved access to this on line format will enable new school nurses to become certified by DOE through out the year as opposed to once yearly during a summer course which historically has been difficult to attend by new nurses. The Standards of Practice; School Health Services manual has been completely up- dated in 2010, and will be reviewed each year by a sub-committee to the Joint School health Committee to assure it remains current with evidence based practice.

In 2000, the Vermont legislature passed Act 125, which directed the Departments of Health, Education, and Buildings with the implementation of interventions to create safe and healthy school buildings. An Act 125 Task Force was created, with representation from many organizations addressing asthma in particular. The work of the Task Force led to the development of the Envision Program at the Health Department. The Envision Program provides grant funding to schools to participate in a model school environmental health program that is based, in part, on EPA's Tools for Schools. Technical assistance provided includes information about implementing measures like safe cleaning practices, regularly scheduled heating and ventilation maintenance, and alternatives to pesticides to reduce asthma triggers. All of the schools participating in the Envision program are at different stages of incorporating the best practices to reduce exposure to environmental triggers.

After the AHS reorganization in 2005, the CSHN director is now a participant in the interagency/consumer committee reviewing home care programs now clustered in the new Department of Disabilities, Aging, and Independent Living; these include Medicaid Personal Care Services, High-tech program, and the Medicaid Home and Community Based Services Waiver for Developmental Services (all of these programs are Medicaid-funded). The focus is on improving the PCS application process for children and maintaining supports in a year of severe budget cuts in Medicaid. CSHN is also exploring assuming the responsibility for clinical determinations of Katie Beckett Option (TEFRA option; in VT also known as the "Disabled Children's Home Care Program"--DCHC) eligibility. CSHN is also represented on the VT Developmental Disabilities Council; the DOE Regional Autism Centers Initiative; the Autism Task Force; the TBI board; the ICC for Part C. In 2008, CSHN spearheaded an interdepartmental committee to reassign responsibilities for Katie Beckett (KB) determinations. The Disability Determination Unit within the Department for Children and Families, which already determines SSI eligibility and also the first step towards KB eligibility, began, in November 2006, to complete the institutional level of care determinations for KB as well. The CSHN program feels this change has been working very well. The Regional Autism Center discussion prompted a new legislative directive, S. 121, creating a statewide, inclusive study process, to result in a report and a plan-for-a-plan. CSHN also participates in the re-design process for the Hi-tech home care program for children (Medicaid-funded, within the Department of Aging and Independent Living). UVM's VCHIP program added a new focus on chronic disease in children; the CSHN medical director is the liaison to VCHIP for these projects. The CSHN medical director joined the VT Developmental Disabilities Council in June, 2008, replacing her membership on the ICC for Part C. In 2010, CSHN Medical Director becomes a member of newly formed Autism Advisory Committee and the Pervasive Developmental Disorders Diagnosis Committee. CSHN continues on the Consumer Advisory Board for UVM's UAP, grant to the UVM LEND program, Vt Interdisciplinary Leadership Education for Health Professionals.

Vermont Department of Health Planning Initiatives (See also III B Agency Capacity and III E State Agency Coordination)

The Health Department is planning its work on Healthy Vermonters 2020 through the selection and prioritization of objectives found in the draft document, Healthy People 2020 Objectives. This process will allow Vermont to focus attention on those national objectives that are of greatest concern for its citizens. The selected objectives and related strategies will be coordinated with the planning efforts described in Title V and the VDH strategic planning. Other examples of other ongoing major planning initiatives: Oral Health Plan, Obesity Strategic Plan, Injury Prevention, Prenatal Smoking Cessation, Domestic Violence Prevention (via AHS), Prenatal Smoking Cessation, Blueprint for Health, Suicide Prevention, Cancer Prevention, Asthma Prevention.

An attachment is included in this section.

B. Agency Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants:
Prenatal and Postnatal Program: The Healthy Babies, Kids and Families System of Care has become incorporated into the Children's Integrated Services along with the programs of Part C and children's mental health services. See III E.

Family Planning Program provides medical services: physical exams, screening for cancer and sexually transmitted diseases, contraceptive methods and pregnancy testing; education and counseling about reproductive health, breast self-exam, STD/HIV risk reduction, pregnancy and infertility; and community education programs such as mother-daughter seminars, school-based education and professional seminars. Services are provided via funds contracted to Planned Parenthood of Northern New England (PPNNE), and are offered at 12 PPNNE sites statewide. All services available via sliding fee schedule for those with incomes up to 250% FPL; no one is turned away because of inability to pay. Services targeted to women of child bearing age, particularly those of low income and under age 25. Services to men are available, and young men are encouraged to participate in counseling and education with their partners. VDH and PPNNE collaborations on screening and referral for clients using both organizations' services. Closer coordination potential for VDH and PPNNE and other private providers in working with Medicaid on the new Affordable Care Act of 2010 regulations allowing Medicaid payments for family planning services. SPM #1.

The VDH Sexually Transmitted Disease Program monitors prevalence of STI's and collaborates with state and community organizations such as Planned Parenthood, American Red Cross, Department of Education and many local groups (such as Vermont CARES) to direct efforts at prevention and treatment. In 2010, a new website was launched with information about HIV testing www.gettestedvermont.com. Site is the result of collaboration between VDH, Fletcher Allen Health Care, and community based organizations.

Pediatric Genetic Services are provided via VDH contract with FAHC Children's Health Care Services which operates the Vermont Regional Genetics Center. Services include genetic counseling to families, evaluation, diagnosis, and treatment of genetic conditions; public information programs about teratogens, a pregnancy risk information toll-free hotline; and TA to VDH (NBS/metabolic.) The pediatric geneticist participates in the CSHN Metabolic Clinic and Newborn Screening Program, and the CSHN Craniofacial program. Newborn Screening Program provides for the genetic screening of occurrent births via legislation adopted in 1996 requiring screening for the following: phenylketonuria, galactosemia, homocystinuria, maple syrup urine disease, hypothyroidism, hemoglobinopathies, and biotinidase deficiency. In 2005, the NBS panel was upgraded via legislation to include 14 additional conditions. Thus, of the 29 ACMG recommended conditions, Vermont screens for 28 in all birth hospitals. Vermont uses the New England Newborn Screening Laboratory at UMass for processing specimens. Organizationally, NBS is a program within CSHN and includes both "heelstick" and hearing screening components. The NBS Advisory Committee recently recommended adding cystic fibrosis to the screening panel. Thus CSHN has developed a new fee structure to support both heelstick and hearing lab and follow-up components. In 2010, CSHN is interviewing for a new nursing position to provide backup to the Newborn Screening Chief (also a nurse), to coordinate clinical follow-up for identified infants and older children through the CSHN Metabolic Clinic, as well as other duties.

Vermont Regional Perinatal Health Project at UVM/VCHIP (partially funded by Title V) provides professional education, transport conferences, and statistical analysis for individual hospitals and providers who treat medically high-risk pregnant women and neonates. Close collaboration with many statewide initiatives, such as the Birth Information Council, and QI efforts with birth hospitals. A 2009 March of Dimes grant allows statewide research project to assess adherence to obstetrical standards for low risk elective inductions and elective Caesarean sections and pediatric standards of care for late preterm infant with goal to reduce the rising rates of late

preterm births. See NPM 17.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a nutrition and education program benefiting infants, children under age 5, and pregnant, postpartum and breastfeeding women with low-to-moderate income levels. Via contracts with local vendors, WIC provides home delivery of selected foods tailored to individual and risk factors. Group nutrition education is offered at least twice during the client's certification period. Individuals with specific nutrition-related concerns receive additional personalized counseling from public health nutritionists. Programs such as the EPSDT Program, Immunizations, Children's Integrated Services, and family planning are integrated or coordinated with WIC. VDH uses a joint WIC/Medicaid application form that automatically assesses and identifies Medicaid eligible clients to expedite Medicaid enrollment. WIC operates a statewide Farm to Family Program. In October, 2009 WIC began its revised food package. Exclusively breastfeeding women and their infants began receiving the greatest quantity and variety of foods. Home delivery is continued and EBT card were added for purchase of fruits and vegetables at participating grocers. This system accomplished in conjunction with "Three Squares Vermont" the state's food stamp program. Other new foods choices are whole grain breads and cereals, low fat milk and cheese, soy and tofu. In 2009, WIC began a nationally developed competency based training program for staff statewide. WIC manages a comprehensive and innovative breastfeeding education and support program - see NPM #11.

Preventive and Primary Care Services for Children:

Division of Mental Health: The Child, Adolescent and Family Unit (CAFU) oversees aspects of the mental health system which serves child and their families and the 10 community based designated agencies (DA) and 1 specialized agency (SA) DMH is responsible for the oversight in these agencies, oversees and monitors the children's home and community based mental health waiver for children identified as having a serious emotional disturbance and are at risk of hospitalization - children can receive intensive services designed to keep them in home/community and out of psychiatric inpatient. DMH oversees the psychiatric hospitalization of Medicaid children, is part of the Case Review Committee responsible for the oversight of any Medicaid child going to a residential treatment facility and works with mental health agencies to assure community plans address all the mental health needs of the child and family. Contracts with psychiatrists offer psychiatric consultation to pediatricians' offices in order to address the shortage of psychiatrists. CAFU is working with CPH and VCHIP to develop a depression screening tool to be used for youth when seen for well child checks in primary care settings - as of 2010, this initiative has reached 30 practices. CAFU works closely with Dept. of Education, Developmental Services and Field Services to assure children are getting coordinated plans to address all their treatment needs. In 2005, the DMH was incorporated structurally into the Department of Health. In 2007 new legislation re-created a separate Department of Mental Health with retaining several infrastructure elements to foster continued coordination with VDH. on issues of physical, mental health and substance abuse and creation of an integrated service model for children and families - recognized by CDC as national model.

Office of Alcohol and Drug Abuse Programs: See SPM # 3. Major initiatives to increase child treatment capacity and quality. Collaboration with VCHIP to increase youth who are screened via strengths based approach and referred for substance abuse and co-occurring problems by PCP Establishing 12 Centers for Excellence for Adolescent Treatment. Collaborated on systems of care for opioid addicted pregnant women and mothers.

Immunization Program: See NPM 7. Vaccine Purchase and Distribution Program purchases vaccines, conducts assessment of immunization coverage, conducts surveillance of vaccine preventable disease, assists in outbreak control, provides education and TA for clinical providers and the public, and develops policies and plans that support immunization strategies and evaluate effectiveness and QA activities. The vaccines purchased by this program are provided without charge to physicians who participate in the Vaccines for Children program. Vermont has a

system of universal vaccine accessibility for children. The VFC Program has 532 providers enrolled at 177 sites statewide. The Assessment, Feedback, Incentives and Exchange (AFIX) Program has evaluated immunization coverage rates for 19-35 month olds in 103 private provider sites. Increasing childhood immunization rates remains priority for Vermont -- issues of complicated administration schedules coupled with restrictions on certain vaccine availability. Planning for expansion of immunization payment system with insurers. Plans for statewide comprehensive social marketing campaign targeted to parents who have reservations on giving their children immunizations and to providers who see these parents in their practices. Coordinate more closely with school nurses for outreach to families.

As of June 22, over 202,000 H1N1 vaccinations had been administered statewide, with approximately 62 percent of pregnant women, 68 percent of household contacts with children under 6 months, 43 percent of health care workers and EMS staff, 55 percent of persons aged 6 months to 24 years, and 25 percent of persons with higher risk health conditions 25 to 64 years of age (all target groups) receiving the immunization. Furthermore, over 600 school and public vaccination clinics were successfully conducted.

Childhood Immunization Registry records immunizations and tracks eligibility for the VFC. Birth data is entered automatically within 10 days via the Vital Births data system. Goals: higher immunization levels, generate immunization records and corresponding documents for child care operators and school personnel, provide easier assessment of current immunization status by health care providers. The Registry contains immunization records for 90% of Vermont children (41,370 individuals) under age 7 and immunization records for 88% of Vermont children (113,428 individuals) under age 18. The Newborn Screening data and the Hearing Outreach data are presently being connected to the Immunization registry via secure web interface within the VDH SPHINX database so as to be available to clinical providers.

Childhood Lead Poisoning Prevention Program (CLPPP) - IVB State Priorities/SPM#10.

Early Periodic Screening, Diagnosis and Treatment (EPSDT) coordinates closely under an interagency agreement with DCF and the state Medicaid agency. Services for children (families making up to 300% FPL) include: education on preventive health care/age-appropriate health screening; assistance with scheduling medical/dental/ health-related appointments; assistance in locating medical/dental providers; information/referral on health and community services, and targeted follow up. Vulnerable children are prioritized, such as those in foster care and children of migrant workers.

Nutrition Services Program (Non WIC and Non CSHN) Activities: integrating nutrition into the Department of Education's Comprehensive School Health Guidelines, providing training curriculum for teachers, activities related to reducing obesity as funded by CDC and planning around Fit and Healthy Vermonters, the state obesity prevention plan. /2008/new Nutrition Chief appointed in 2006. Primary responsibilities include oversight of Fit and Healthy Vermonters Obesity Prevention Plan (funded via CDC.) Also facilitate and coordination of nutrition services across the Department, serving on the Governor's Hunger Task Forces, working with community coalitions to promote nutrition and physical activity interventions, and identifying policies and best practices for environmental changes to support health behaviors. Collaborating with Attorney General's Task Force on Obesity Preventing. See SPM #4 and #6.

Office of Oral Health provides dental consultation to the Medicaid/Dr. Dynasaur program by determining prior authorizations on several dental procedures, including orthodontics. There are several early childhood caries prevention efforts among family practitioners, pediatricians, primary care providers, dentists, dental hygienists, and VDH. The School-based Fluoride Mouthrinse Program has been in existence for 33 years, providing free weekly fluoride mouth rinse to children in schools that do not have community water fluoridation. Over 90% of eligible Vermont schools participate. Tooth Tutor Dental Access Program, which began in 1999, reaches out to Medicaid eligible children via Early Head Start, Head Start and elementary schools to facilitate

enrollment in a dental home. Several middle schools and high schools are now participating. An extensive state oral health plan was created in 2004-2005. The "Oral Health Plan resulted in a legislatively approved program called the "Dental Dozen" -- 12 targeted initiatives to improve access, quality of oral health services, assure adequate dental workforce for Vermont's future and increase Medicaid fees for dentists participation in the Medicaid program. In 2009, a Dental Hygienist was placed in large pediatric practice to train providers in oral health risk assessment and also to assist as needed families to find a dental home. A Dental Director was hired in August, 2009. Six Dental Access Grants were awarded to assist practices to increase the numbers of patients with Medicaid who they serve. In 2010, a school based oral health survey of 1st, 2nd, and 3rd graders was conducted to gather up-to-date information regarding the oral health status of Vermont's children. Support has been given to independent efforts to improve children's access to dental care, including a mobile dental van, hygienist practices in school based settings, and a collaboration between pediatric dentists, physicians, and Head Start programs. In 2010, the Office of Vermont Health Access approved payment for the application of fluoride varnish by medical professionals. In 2011, efforts will be focused upon building coalition support to continue to increase access, promote efficiency within existing programs, and increase promotion of recent initiatives.

Emergency Medical Services - Children (EMS-C) insures improvement of pediatric outcomes in prehospital environment by represent pediatric emergency care issues in all aspects of the emergency medical service system Examples: ambulance equipment surveys, assessment of medical direction during transfers, refine inter hospital transfer agreements/policies, develop a prehospital data collection plan.

Dept for Children and Families: Sept 2008 began a new system of statewide centralized intake of suspected reports of child abuse replacing former system of reporting directly to field offices - creates more uniform and professionalized system of response. Differential Reporting uses risk assessment on every report of child abuse allowing the lower risk cases to be handled with support services as prevention effort rather than use of traditional stronger intervention.

System of Care for Children with Special Health Care Needs:

PYRAMID LEVEL: DIRECT SERVICES:

CSHN continues to manage and subsidize a statewide network of multidisciplinary services: Clinics/Programs which are directly staffed and managed by CSHN include: Orthopedics (including also Hand and Myelomeningocele); Child Development Clinic, Metabolic, Craniofacial, and Feeding Clinics, and Seating, Nutrition, and Hearing (Hearing Outreach Program and Hearing Aid Purchase) Programs. Clinics/Programs which are supported through contracts, and which CSHN staff (nursing and/or social work) attend are: Cystic Fibrosis, Juvenile Rheumatoid Arthritis, and Neurology/Epilepsy. Clinics/Programs which we support through contracts and with which we collaborate but do not attend staff directly include Dartmouth Child Development Program (CSHN and Dartmouth co-fund the clinic coordinator), Hemophilia, FAHC NICU medical follow-up (providing the developmental screening component) and the clinic of Vermont's LEND program (Interdisciplinary Leadership Education for Health Professionals--ILEHP). CSHN has become a direct provider of "Therapy Clinic" services under Medicaid, through which community based PT, OT and SLP are enrolled as credentialed providers, contractor-employees of CSHN, which, in turn, is able to bill Medicaid. The "Clinic" is not a site, per se, but delivers therapy services directly to children in their homes and communities. CSHN continues its intensive review of the Child Development Clinic, redefining its proper niche as a provider. In 2008, after the retirement of another developmental pediatrician, the Child Development Clinic physician staff include: A half-time (state employee) pediatrician, two half-time contractor developmental pediatricians, a part-time child psychiatrist, and the CSHN medical director has just begun to see CDC patients half-time as well. CSHN is expanding contracts with Dartmouth, and continuing contracts with UVM for this purpose. The St. Albans CDC site has been active for about a year, with the lowest no-show rate in the state and much positive feedback from providers and families.

A pediatric urologist arrived in April 2007. We have added a pediatric physiatrist (physical medicine and rehab), contractor, part-time, as a part of our orthopedic program. A full-time pediatric neurosurgeon began her practice at FAHC/UVM in Spring, 2008. Her responsibilities include participation in the CSHN Myelomeningocele program. Recent reductions in the number of state government positions have affected all areas, including direct services in CSHN and elsewhere. CSHN has not been able to fill most of the year's nursing and social work retirements/resignations at this time. As of 2010, The NFI grant aims to refocus efforts towards specialized care coordination in partnership with primary care, and to expand Child Development Clinic resources in connection with AHS Integrated Family Services. This year, three regional orthopedic clinics were ended, with staff supporting families towards the care of tertiary specialists. At the same time, however, CSHN has increased access to physiatry services through an itinerant clinic team model not available at tertiary care. This service reaches a broader population of children with physical disabilities (beyond those who might have needed orthopedic surgery at a point in time) and addresses adaptive and mobility needs, as well as including adolescents.

PYRAMID LEVEL: ENABLING SERVICES

CSHN Financial Assistance Program: CSHN continues to provide after-insurance funding of medical services when these services have been pre-authorized by CSHN clinical staff and when they fall within the range of services permitted by CSHN guidelines. Changes (largely reductions) in Medicaid accessibility (increased premiums; tighter interpretations of medical necessity) have resulted unavoidably in some costs shifts to CSHN, but more importantly, loss of coverage of other services for CSHCN, such as primary care. CSHN staff work diligently to help families apply for and maintain their children's Medicaid coverage. In 2008, all three of the independent PT/OT/ST agencies providing services to children have experienced major setbacks this year. One has closed; one is no longer willing to bill Medicaid, which will result in a cost shift to CSHN for services CSHN prescribes; and one has decided not to enter any agreements to bill insurance (and has never accepted Medicaid). Other regional therapist shortages have also complicated service coordination and access for families with CYSHCN. However, as of 2009, all therapists in private practice are now eligible to enroll as Medicaid providers (institutions and clinics have been eligible for many years.) CSHN, therefore, is requiring, as of 12/31/09, that therapists complete enrollment in Mediciad in order to serve CYSHCN who use Medical. The fee differential between CSHN payment and Medicaid payment for PT/OT is minimal and CSHN will assist therapists in the logistics of enrollment. Speech therapy remains a funding challenge and may not be subject to the Dec date.

Special Services Program: CSHN continues to provide medical care coordination, through regional social work and/or nursing, and financial access to specialized services, for VT children who have a condition that CSHN covers but for which no established clinic exists. CSHN pediatric nurses and medical social workers are based in regional offices and are involved in care coordination. Families are referred to CSHN from hospitals, Medicaid high-tech program, and others; CSHN MSW's are also members of the regional Part C Core teams (direct service teams); this role has continued, even though the Part C program has been transferred to the new Department for Children and Families in the AHS reorganization. The 2009 state position cutbacks have strained our capacity to cover all FITP regions.

CSHN has successfully blended its accounts payable process with that used by Medicaid and Part C. A single fiscal contractor (HP, formerly EDS) enrolls all providers, applies established fee agreements, sequences payers, and processes payments. In addition, CSHN and Medicaid have aligned their determination of medical necessity. CSHN's and Medicaid's physical therapist consultants work side by side to review authorization requests, to achieve a consistency irrespective of health care coverage. The NFI grant continues to support an examination of the future role of CSHN as a health care payer.

In response to the Challenges for Change mandates--but also because the process makes good sense--CSHN is discussing, with programs serving overlapping populations of children, how best to integrate our approaches to eligibility and care coordination. Although the legislative goal is to save state dollars, the discussions are fruitful and promising as we use case studies to understand how our programs intersect and how they might be blended. The programs are part of the Department of Disabilities, Aging and Independent Living (DAIL), Division of Developmental Services, and include the Children's Personal Care Services program, the Bridge Program (regional DS case management, through community-based non-profits), and the Children's Hi-Tech program (in-home nursing for children assisted by technology). Both the cross departmental planning and the DAIL use of non-profits are particular "challenges" for "change." But such are daily challenges for families, and we are committed to making a sensible and sensitive system.

Respite Care Program: Families receive annual grants or reimbursements to defray the cost of hiring respite care providers. Allocations are based on the skill level of the care needed; eligibility is based on enrollment in CSHN, income and ineligibility for respite care from other programs. For 2010-2011, in the CSHN budget, eligibility criteria, and allocation amounts remain unchanged at $295,000. Enrollment is projected at 520 families, including 15 who receive a $150 one-time allocation, while waiting for respite from the Division of Developmental Services.

Parent to Parent of Vermont receives funding from CSHN to support its statewide network of programs, which include supporting parents, outreach to community providers, pre-service and in-service training to medical and early intervention staff and students, continuing education, and participation in program and policy design for CSHN. Part of the funding specifically supports a parent as Children's SSI Coordinator, providing outreach information and referral. In 2008, Parent to Parent (P2P) and VT Parent Information Center (VPIC) merged to form the Vermont Family Network (VFN). Both agencies receive infrastructure support from CSHN and provide CSHN parents with support and information about health care (P2P) and education, including health related services (VPIC); both also provide CSHN with valuable data gleaned from parents for needs assessment. In 2010, with support from the NFI grant, CSHN has contracted with VFN to add a Parent Liaison position 20 hours per week. The parent has an office pod at CSHN and receives referrals from CSHN staff. CSHN has funded the infrastructure VFN for 20 years, to support their many outreaches to families, but this is the first time that we have co-located with a staff member.

In-Home Support Program: Medicaid funds Personal Care Services (PCS) for in-home support for children with severe disabilities. CSHN serves as one of several access points providing referral to PCS. As of 2010, CSHN MSW's continue to perform PCS renewal applications for a small number of long-term patients. Home health agencies providing direct services, and Developmental Service agencies which have received new case management staff are providing many new and renewal applications for families. Some FITP regions also perform this service for their families. VFN has also received permission from Medicaid to perform assessments/applications.

Nutrition Services: CSHN/Part C-IDEA and a state-level pediatric nutritionist who is developing and expanding the capacity of community-based nutritionists to provide local consultation to CSHCN. The state CSHN nutritionist reviews each client evaluation, assists in the development of the plan of care, and provides technical assistance in the treatment. CSHN also manages a nutritional formula program for children needing special formulas or "nutriceutical" treatment of their chronic condition. CSHN developed agreements with the major insurers and Medicaid to function as a clearinghouse for medical foods for children. In a small state with few nutritionists, it is often a struggle to maintain staff continuity in each of the 12 AHS regions. The CSHN nutrition consultant fills in, as she is able, while recruiting local dieticians to join the network. As of 2010, the CSHN nutritionist has recruited and trained 3 new regional nutritionists for the state. Only one region remains without regional coverage; the CSHN nutritionist continues to serve the region directly in the interim.

Family, Infant and, Toddler Project (FITP) is the statewide early intervention system of care for infants and toddlers with developmental disabilities, funded by Vermont's federal Part C-IDEA grant. FITP was transferred to the new AHS Department of Children and Families for continued administration and for delivery of services regionally. Each of the 12 AHS districts has established its own regional planning team, designated host agency and developed programs that comply with Part C rules. CSHN regional social workers are members of FITP regional interdisciplinary service teams, smoothing the transition at the child's 3rd birthday and offering some continuity in a child's team composition.

PYRAMID LEVEL: POPULATION-BASED SERVICES

Newborn Screening Follow-up: See NPM 1. Vermont has strong newborn screening programs, assuring that well over 90% of all newborns are screened in a timely way and receive timely followup. Vermont recently expanded the number of congenital conditions for which babies are screened, from 7 to 21 conditions. Since July 2003, all VT birth hospitals have screened all newborns for congenital hearing loss. CSHN is responsible for the assurance and follow-up, overseen by a full time pediatric audiologist (through a grant to UVM), and largely implemented through the direct service of the Hearing Outreach Program, also by pediatric audiologists. Vt is charged with sustaining these population-based efforts through fees, rather than grants. The VT legislature has passed the Birth Information Network statute, and the CDC has funded its initial development and implementation, with the goal of earliest possible identification of certain congenital conditions and the assurance that identified babies have access to needed early intervention and health services. CSHN also participates in population-based screening (by referral) through HOP for older children up to age three, or those of any age who are difficult to screen by other methods.
In 2007, the CDC funded a new cooperative agreement with CSHN/VDH to integrate the screening and tracking information currently housed in MS Access databases into the emerging VDH "SPHINX" information system. NBS/UNHS will join ERBS and the immunization registry in a child health status integrated database, with web-based inputs and outputs. Statewide CF screening, implemented on March 1, 2008 - preparation included protocol development with three tertiary care centers who will provide follow-up sweat testing and counseling for positive screens, outreach education to PCPs, and cross-state-border discussions. In 2010, the implementation of the newborn hearing screening data system has begun, so PCPs can access their patients' results through the web-based Child Health Profile.

PYRAMID LEVEL: INFRASTRUCTURE-SYSTEM BUILDING ACTIVITIES

"Children receive regular ongoing care within the medical home" See NPM 3, P Need 1.
"Families have adequate insurance to pay for needed services" See NPM 4.

With the expansion of Dr. Dynasaur (Medicaid and CHIP) to 300%FPL, Vermont continues to improve the percentage of children who have a source of adequate health care coverage. As a payer of last resort for many medical services, CSHN has developed and strengthened its internal financial processes to help families apply for Medicaid, understand their own private health insurances, and pursue benefits to which they are entitled. In the gap, CSHN has continued to be a payer. Medicaid has delegated to the CSHN director the responsibility for determination of the medical necessity and authorization of continuation of services for OT, PT, and speech services for children after they have received them for a year. Through its Seating Clinic, CSHN also reviews and facilitates the ordering of wheelchairs and other seating and positioning equipment, as well as the coordination of insurance and Medicaid coverage for the equipment. At the same time, the collaboration with Medicaid in the prior authorization of individual services also is the basis for systems-level solutions to coverage issues that arise with individual children. In 2006, Medicaid resumed the direct responsibility for PA for therapies last year. Productive discussions and advocacy with Medicaid have resulted in (1)a less-frequent renewal necessary for children with chronic therapy needs; (2)independent Medicaid medical necessity determinations for

children whose primary private insurance has denied coverage for an essential service and all appeals have been exhausted; (3)advocacy for coverage of previously uncovered items and services. CSHN continues to note the impact of CSHN families' need to pay monthly premiums prospectively as a source of dis-enrollment from Medicaid. As described elsewhere, CSHN reviews all 4-5,000 enrolled children's Medicaid status monthly, notes whose Medicaid coverage has lapsed or is about to lapse, notifies the families' CSHN clinical contact person, and attempts to support families with maintaining continuity. We have received staff training/information on the complex options available to young adults to transition to adult forms of health insurance (VHAP, Catamount, COBRA, etc.) In 2010, CHSN has seen some families move successfully onto Catamount coverage in this past year. Because we support and advocate for families in accessing their benefits, we are able to see trends in coverage. This year we have noted particular difficulties in coordination of benefits for families who have both private insurance and Medicaid; some families have chosen to drop their private coverage. Obtaining and maintaining Medicaid coverage is a complex process for families with CSHCN. Prospective monthly premiums whose omission causes a month without health coverage, transition from Dr. Dynasaur to other forms of public insurance at age 18--at the same moment that a newly-minted adult has to navigate the eligibility process on his own, coordination of benefits when a family also has commercial insurance, all conspire to create discontinuities in coverage.

An attachment is included in this section.

C. Organizational Structure

The Agency of Human Services is the largest of the agencies of state government, and is headed by the Secretary of Human Services, who reports to Vermont's governor. The Vermont Department of Health (VDH), within the Agency of Human Services (AHS), administers the Maternal and Child Health (MCH) Block Grant, also known as Title V. Most Title V related activities occur through two divisions of the Vermont Department of Health: the Office of Local Health and the Division of Maternal and Child Health. MCH includes the programs of Children with Special Health Needs which are overseen by a medical director. CSHN contains the programs of Newborn Metabolic Screening and also Newborn Hearing Screening. MCH also includes the WIC program, EPSDT, injury prevention, family planning, and school health services. The MCH Director has the responsibility for the implementation of the entire Title V grant. As part of the oversight of the grant, the MCH Director meets regularly with the appropriate partners within VDH, with outside contractors receiving funds from Title V, and with state and community partners involved in MCH related activities. Emergency Medical Services for Children is sited in the Division of Health Protection. The STD/AIDS program is in Health Surveillance. The Office of Local Health has oversight of the VDH services as administered out of the twelve VDH district offices. As a result of the 2005 state government reorganization, the oversight of Healthy Babies Kids and Families is shared with the Department of Children and Families (also under the Agency of Human Services.) The Department of Children and Families also manages the Family, Infant, Toddler Program (FITP) and Childrens UPstream Services (CUPS). These three programs are being coordinated into one program of Children's Integrated Serivce (CIS.) VDH also oversees the state's Substance Abuse Services.

The Agency of Human Services consists of several departments responsible for services for children and families, such as the Department of Health, the Department for Children and Families, the Department of Disabilities, Aging and Independent Living, the Department of

Corrections, and the Office of Vermont Health Access. AHS has 12 field offices that coordinate closely with the VDH's twelve District Offices. 12 AHS Field Service Directors oversee services in each AHS district and coordinate among the state's departmental offices. The VDH District Offices serve as local health departments and cover the entire state. VDH local DO's work closely on case management and service coordination with the local state and community offices that provide social, health and welfare services -- also with the community health centers and AHEC districts. At the state level, the community health centers are part of the Primary Care and Rural Health programs. Within VDH, collaboration are between MCH, Health Promotion and Disease Prevention, Office of Local Health, Protection, Alcohol/Drug Abuse and also with the Department of Mental Health and the Department of Education. In addition, a close relationship exists between operations and program planning and the data and research office of the VDH. The collaboration has been critical in the preparation of the Title V grants and needs assessments and also with the preparation of federal ACA grants of 2010.

State wide organizing and collaborative groups deal with many public health and MCH issues. The VDH and MCH has representation on many of these groups, such as Injury Prevention Advisory Group, the Child Fatality Review Team, The Domestic Violence Fatality Team, the School Health Coordinating Committee, the CIS planning committee, those committees dealing with physical activity and nutrition, Medicaid planning and reimbursement, CSHN coordination and clinical services, oral health coordination, coordination with AAP and Family Practice, and breastfeeding coordination. These groups and their work are discussed also in the various section of this grant application.

CSHN has a strong partnership with the Vermont Family Network (VFN.) VFN reaches a much broader population than the direct service programs of CSHN, and has been enabled, through the Title V support, to create a data system to track and categorize expressed needs and concerns, as well as insurance demographics, of families who contact the organization. VFN is funded as a family to family organization and undertakes surveys and projects which also gather information about needs. Vermont Child Health Improvement Program (VCHIP) focus on quality improvements in the care of children with chronic diseases -- assists categorical clinics (ie endocrine clinic) to identify needed areas for improvement. Themes emerging are need for better patient management data systems. MCH has a strong partnership with the VT chapters of the AAP and AAFP. Monthly meetings, as well as task forces, help to identify health care and systems issues affecting CYSHCN including children who have mental health conditions. VCHIP plays a role in hosting these efforts and providing guidance in the improvement strategies resulting from identification of problem areas. Vermont has received a 3 year CYSHCN State Implementation Grant - focus on outcomes in Medical Home, Health Care Financing, and Integrated Community Services, and will include family partnerships throughout. Also, the SIG will develop system complementary to other systems building initiatives at VDH, such as Oral Health and the Blueprint for Health (concentrating on chronic disease in adults.) The SIG collaboration with AHS/CIS, blending Part C, MCH home visiting (Healthy Babies, Kids, Families) and early childhood mental health (CUPS) July 2009 implementation of regional CIS Teams will begin using regional phased in approach. Regional teams will provided intake, assessment, and a single plan of care for children 0 -- 6 years old. Vital links with CSHN have been considered in the CIS design of local, community based, streamlined and easily accessible systems of care. Dr. Davis and Dr. Holmes have been spearheading VDH contribution to CIS along with SIG project coordinator in state team and workgroup efforts -- thus CYSHCN/MCH perspective has been included wherever possible throughout the multiple integration efforts that are taking place across AHS services and programs. These programs of CIS are to be involved with the planning and implementation of the upcoming home visiting program as funded by the 2010 ARA legislation.

Centralized planning at the AHS has increased in momentum as a result of the passage of Challenges for Change. Steve Brooks, CSHN director of operations/MCH administrator, is part of the core leadership of the Children's Integrated Services/Integrated Family Services planning and implementation process, an essential voice in the balance of health perspectives in the evolving

system. Breena Holmes, MD, has also joined the process as the new MCH director. Her experience as a primary care pediatrician, a practice director, a health education teacher at the high school level, and past vice president of the VT chapter of the AAP, gives a breadth and depth of practical understanding . The planning entered a more concrete phase, with discussion of a common intake, a single electronic record, and a first round of piloting an RFP process for a single budget for 0-6 year olds at the regional level.

An attachment is included in this section.

D. Other MCH Capacity

Commissioner of Health
Dr. Wendy Davis graduated from the University of Virginia College of Medicine, completed her pediatric residency at Case Western Reserve University and general pediatrics fellowship at Yale University. As of January, 2007, Dr. Davis began serving as Director of Maternal and Child Health at the Vermont Department of Health, where she enjoys working on initiatives related to child health promotion and disease prevention. In June, 2008, she was appointed to the position of Vermont' Commissioner of Health.
Dr. Davis is a Professor of Pediatrics at the University of Vermont College of Medicine and serves as a senior advisor to the Vermont Child Health Improvement Program, an organization dedicated to improving the health of children in Vermont and nationally. She has served as president of the medical staff and as a member of the Board of Trustees at Fletcher Allen Health Care. Dr. Davis is past president of the Vermont Chapter of the American Academy of Pediatrics. Key accomplishments during her presidency included helping to formalize a partnership with the Vermont Department of Health and providing consultation in a number of areas related to improving pediatric preventive health service delivery. In 2002, she received the Chapter's Green Mountain Pediatrician Award. She is a member of the team that is developing a toolkit to accompany the 3rd edition of Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Director of the Division of Maternal and Child Health
Dr. Breena Holmes was appointed the Director of Maternal and Child Health at the Vermont Department of Health in February, 2010. She holds a teaching position at the University of Vermont School of Medicine where she is Clinical Associate Professor of Pediatrics. Dr. Holmes has a passionate interest school health and provides leadership for the Vermont Committee on School Health and serves on the American Academy of Pediatrics Council on School Health. In a previous role, she served as the school physician for Middle Union High School where she revised and taught the school health curriculum. In addition, she was a pediatric practitioner at Middlebury Pediatric and Adolescent Medicine and also Chair of the Department of Pediatrics at Porter Medical Center in Middlebury, Vermont. Dr. Holmes graduated from the University of Massachusetts Medical School and completed her residency at the Seattle Children's Hospital and Medical Center.

Medical Director of Children with Special Health Needs Programs
Dr. Carol Hassler graduated from Radcliffe College in 1972 and earned a MD from the University of Pennsylvania in 1976. Her residency in Pediatrics took place (in 1976-1978) at the University of Virginia, and Dr. Hassler held a fellowship in Child Psychiatry at the University of Virginia (1978-1980), where she also served as Chief Resident from 1979 to 1980. She has served as the Director of the Division of Children with Special Health Needs at the Vermont Department of Health from 1990-1995, Director of the CSHN Unit within MCH from 1995-2008 and Director of Handicapped Children's Services at VDH from 1985-1990. She is Board-certified in pediatrics and is a Fellow of the AAP. Dr. Hassler also serves as Clinical Associate Professor of Pediatrics

at the University of Vermont College of Medicine and as an Attending Physician at the Fletcher Allen Health Care Hospital. In the 2008 reorganization of the Vermont Department of Health and the Division of MCH, Dr. Hassler became the medical director for the CSHN Unit and the Director for the Child Development Clinic. In addition, she has become board certified in Neurodevelopmental Disabilities through the American Board of Pediatrics./2010/ Dr. Hassler earned her special certification in Developmental and Behavioral Pediatrics in 2009. She spends a significant portion of her time in patient care supervision in the Child Development Clinic.//2010//

Director of Operations for Maternal and Child Health
Stephen Brooks graduated from Castleton State College, Vermont, and did graduate studies at Middlebury College, Vermont. He has worked with the Vermont Department of Health's program for Children with Special Health Needs since 1989 and is currently the CSHN Operations Director. Areas of particular interest are Systems Development, Quality Improvement, Practice Management, and developments in Family Centered care. Mr. Brooks participated in the Children with Special Health Care Needs Continuing Education Institute, in Columbus, Ohio and has a certificate in Physician Practice Management from the New England Healthcare Assembly. He has represented the Vermont Department of Health on a number of New England-wide workgroups sponsored by New England SERVE. The products of these workgroups included the publications Enhancing Quality; Paying the Bills, a Guide for Parents; and Ensuring Access. In addition to his work with CYSHCN, he has also been the state coordinator for the Preventive Health Services Block Grant for the past several years. Mr. Brooks has served on the Board of Directors of Parent to Parent of Vermont, the state's Family Voices program and is active with Vermont CARES, a statewide HIV/AIDS service organization.

Director of the Office of Dental Health
Dr. Patrick Rowe was hired in the summer 2009 to fill the full time position of Vermont Department of Health Oral Health Director. After graduating from the State University of New York -- Buffalo School of Dental Medicine in 2003, Dr. Rowe completed a General Practice Residency at the Veteran's Affairs Medical Center in San Francisco, CA. Dr. Rowe spent time as an associate in private dental practice in the San Francisco Bay area before accepting a staff dentist position at a community clinic in Santa Cruz, CA. After gaining exposure to the policy environment through the American Dental Education Association while teaching part time at the University of the Pacific Arthur A. Dugoni School of Dentistry, Dr. Rowe enrolled in a public health program at the University of California, Los Angeles, and received his Masters of Public Health in 2009. Dr. Rowe joined the Vermont Department of Health as Director of the Office of Oral Health in August 2009. Since that time he has supervised oral health staff, developed working relationships with stakeholders statewide, managed grants and contracts as well as all Office of Oral Health programs, and engaged in public speaking, education, and technical analysis to support community water fluoridation.

Nutrition and Physical Activity Chief
Susan Coburn MPH, RD was appointed the Nutrition and Physical Activity Chief for the Vermont Department of Health in 2006. She is a registered dietitian and has a Masters of Public Health in Leadership from the University of North Carolina at Chapel Hill. She came to the Department of Health in 2002 where she started in the Ladies First program to design and implement the nutrition and physical activity program to reduce cardiovascular disease among limited income women over 40. Prior to working at VDH she was employed by the Vermont Campaign to End Childhood Hunger where she coordinated Cooking for Life, a statewide cooking and nutrition program for limited income parents. She currently oversees the Fit and Healthy Vermonters initiative part of the obesity prevention grant from the Centers for Disease Control.

Public Health Planning and Performance Improvement Director
Tracy Dolan joined the VDH in March, 2009 and is working with the Commissioner and executive staff to ensure excellence in public health programming and to promote integration of services across the department and with partners. Building upon recent planning efforts, Ms. Dolan will be

responsible for the implementation and evaluation of a department-wide strategic plan. As part of her duties, she is also providing oversight to Health Equity efforts, Workforce Development, Patient Safety, and Rural Health and Primary Care. Ms. Dolan has a Masters Degree in Public Health from the University of Northern British Columbia, Prince George, Canada. Her work experience includes extensive strategic planning in multinational settings, development of program standards for various health programs, and international HIV/AIDS health education and program development.

MCH Planning Specialist
Sally Kerschner holds a Masters of Science in Nursing from the University of Vermont and is a Registered Nurse. She has over twenty-five years of experience in maternal and child health and community health nursing. She has worked at the Vermont Department of Health since 1983.

CSHN/Parent to Parent
Through CSHN funding of Parent to Parent of Vermont, CSHN hires parents as Children's SSI Coordinators, providing outreach to Vermont families whose children are eligible for SSI. In addition, several of the CSHN clinical staff are parents of children with special health needs. /2007/CSHN support of P2P is best described as infrastructure support rather than direct hiring of staff. P2P has many family support and system-informing functions which are provided best by families themselves, and we benefit (as families and systems) from being able to undergird their efforts./2009/P2P merges with the Vermont Parent Information Center, to form the Vermont Family Network, in July, 2008. Infrastructure support will continue. //2009///2010/Funding through the NFI grant will support pilot implementation of a part-time parent liaison/family consultant within CSHN to assist with family-centered care and practices//2010//

An attachment is included in this section.

E. State Agency Coordination

There are a wide variety of public health planning, coordination and program activities that have evolved over the past several years which include a range of health and health-related partners both within state government and also the community or private sectors. These collaborations deal with such public health issues such as primary health care delivery, women's health, oral health, obesity, emergency preparedness, health in the schools, injury prevention, QI in health care services, etc. Several examples are detailed below. It has become the culture at VDH and within MCH programs that, to be successful with achieving the goals of any major new public health initiative or project, key community and state partners must be involved. Public health issues are complex and require complex solutions -- which can be implemented via a multidisciplinary approach. With many of these issues, the VDH plays the key role of speaking for public health and modeling the unique role that MCH and public health can offer to the population health solution.

Vermont continues to prioritize the strengthening of community based and statewide systems to support families' access to quality and affordable health care, including those with children with special health care needs. Vermont is considered exemplary in its successes in providing health insurance for its citizens. However, an area in need of attention is the utilization of health care among school-age children and adolescents; the School EPSDT Health Access Program is engaged in efforts to address this issue, along with coordination efforts with the Department of Education. Dental health care access is a longstanding problem for Vermonters and one that the Department of Health is addressing through the activities of the Office of Oral Health Unit, MCH, and the Office of Primary Health Care. The Office of Oral Health has just submitted a CDC grant for oral health planning.

The Vermont Primary Care Collaborative (PCC): Purpose is to coordinate state primary care

activities that promote the development of innovative and progressive primary care health care services for the underserved. The Vermont PCC provides opportunities for community-based providers of primary and specialty care (as well as behavioral and oral health care providers) to work together on state and regional issues and promotes the support and involvement of state agencies in primary care. The PCC representation: VT AHS (VDH: Minority Health and Mental Health), Department of Children and Families, Medicaid); the University of Vermont (College of Medicine, School of Nursing, Department of Dental Hygiene); Bi-State Primary Care Association; Dental Society; Health Care Authority; Coalition of Clinics for the Uninsured; VT Association of Hospitals and Health Systems; Medical Society; Nurses Association; Northern Counties Health Care; VT Long Term Care Coalition; and AHEC. Focused initiatives have been for oral health service needs, workforce development, rural health, veteran's health services, and the health needs of migrant farm worker and their families.

Coordination of Health and Public Health Components of Early Childhood Systems: Community and State-Based Systems: MCH and the Office of Local Health have strong liaisons with Head Start, Early Head Start, and other early childhood programs. Staff from the Immunization Program in the Division of Health Surveillance and staff from Local Health work collaboratively with the DCF Child Care Services to increase the percent of children in child care who are fully immunized. VDH participates in the statewide Early Childhood Workgroup, which was established to coordinate efforts between a variety of state agencies and private, not-for-profit community organizations. VDH also participates in the ECCS grant activities, Building Bright Futures.

Children's Integrated Services is streamlining services from the Family, Infant Toddler Program (Early Interventions Service/IDEA/Part C), Healthy Babies, Kids and Families, and CUPS (early child hood mental health.) These services will be involved with the planning for new home visiting services as funded by the 2010 ACA legislation. The CSHN collaboration includes the use of Medical Social Workers as an IFSP team member and the use of CSHN staff as advisors. In spite of the transfer of the Part C program to the Department for Children and Families (with the purpose of improving integration of the early childhood programs--see CIS), CSHN medical social workers remain members of each core team. The CSHN Child Development Clinic is a major referral to--and referral from--Part C, serving as the medical developmental diagnostic/evaluation resource for the state. We estimate that 40% of children enrolled in Part C also receive services from one or more CSHN programs.

Historically, "Healthy Child Care Vermont" (HCCVT) began via a CISS grant with the intent to build state and local capacity to provide expert public health nursing consultation and training to child care providers. In 2003, the HCCVT initiative began a transition to a new HRSA/CISS grant for infrastructure development of Early Childhood Comprehensive Systems (ECCS), which includes early care, health and education focused integration. The ECCS grant is funded by the MCHB through Title V, to support the public health presence and leadership around five key areas of a comprehensive early childhood system: access to insurance and a medical home; mental health and social-emotional development; early care and education; parent education; and parent support. Also at this time, Vermont received a Technical Assistance grant from North Carolina's Smart Start Initiative to develop a strategic plan for creating a unified early childhood comprehensive system which would be unique to Vermont. This work was directed by a Governor's Cabinet Sub-Committee on Early Access to Care and Education, as well as four workgroups with diverse statewide representation: local/state governance, public engagement, finance and evaluation. In 2004 this system began to become unified under a 'new' name - Building Bright Futures: Vermont's Alliance for Children. In 2004-2005, the BBF Health Subcommittee, co-chaired by VDH and DCF, conducted an extensive planning process under the ECCS grant. HCCVT continues to partner with Child Care Licensing, Community Resources and Referral agencies, Northern Lights Career Development Center, AAP-Vt, VDH, and ECCS Coordinator. Updating Childcare Licensing regulations and health and safety components. BBF regional councils are focusing on quality child care and consultation services. Lack of capacity in staffing capacity hinders ability to do annual on-site visits of child cares (SPM #2.) Other

strategies such as phone consultations and regional inservices are used for TA and education of providers. In 2009, funding cuts and staff reductions have hindered DCF/OLH ability to fully continue with the activities of Child Care Health Consultants - planning as to prioritizing program objectives and possible methods of continuing via other VDH venues.

Children's Integrated Services: As a result of the 2004 AHS reorganization, planning began for a system of services to AHS clients that is holistic, integrated and seamless in order to support pregnant women, infants and children to age 6. Three programs became co-located at the state level: Healthy Babies, Kids and Families, Children's Upstream Services, and Family, Infant, Toddler (Part C). Major partners in this planning are VDH, DCF, and Department of Education. CIS regional planning teams, consisting of staff from the 3 services, have been created and district-specific plans for service integration are being reviewed at the state level. CIS work plans for each region will be connected with concurrent ECCS/Building Bright Futures planning and priority setting around early childhood indicators/outcomes. Leaders from the VDH MCH Division and the Child Development Division of DCF meet regularly to assure integrated delivery of health and early education services. DAIL, Mental Health, and OVHA are also players in the larger planning process. CIS coordinator to be placed in each region, CIS multidisciplinary intake team to review/triage referrals, AHS authorization form for consent to share individual information has been completed. AHS performance based pilot continues in 4 regions to enhance family support services and testing care rate billing structures.

AHS Secretary has charged the MCH director and the special assistant to the AHS secretary to co-lead the redesign of the state system of care for children with disabilities. This is a very timely goal, with the new CSHN State Implementation grant, the maturing of the CIS implementation, and several other related efforts: Act 264 (the expansion of a regional case problem-solving method for children with severe emotional disturbance and special education needs, to include potentially all children who receive special education and services from an AHS program--this is a hierarchical, regional-to-centralized stepwise process to develop comprehensive care plans and assign fiscal responsibility for their implementation); Children's Medicaid Hi-tech program redesign; unified services plans (using Medicaid home and community-based services waivers to bring all fee for service and waiver services for a child into one plan under one budget); completion of a state plan for services for individuals with autism spectrum disorders; Building Bright Futures planning (regional planning for early childhood services, especially early care, health and education via EECS funds); Blueprint for Health (incorporating Medical Homes); case management initiatives within Medicaid; and others. IN 2010, CIS Intake coordinators have begun to be hired by provider agencies to oversee intake/coordinator responsibilities for Regional CIS Teams. VDH MCH Coordinators in each region will be members of the CIS Intake Teams, as will mental health and early intervention (PartC) providers. Connections to CSHN will be made through early intervention and VDH MCH Coordinators. CSHN and CDC services are linked to the CIS teams in a consultative capacity and continue to provide direct services to children and families. A common referral, intake and authorization form will be used by the region teams. CSHN, in collaboration with DAIL, has applied for MCHB SIG for children and youth with ASD and other developmental disabilities. Goal is to improve capacity of adult primary care to welcome individuals with ASD into their practices. CSHN specialty clinics are making progress in "graduating" young adults to adult specialty care providers, also a necessary part of the system. The Vt Blueprint for health, enhancing medical homes for adults, currently targets particular chronic conditions, but intends to expand to the pediatric population.

To address quality improvement for children using Medicaid, VDH has contracted with the University of Vermont College of Medicine's Vermont Child Health Improvement Program (VCHIP) to plan and implement numerous quality improvement projects with a wide range of providers and institutions. Projects ranging from improvement of OB care in birth hospitals to improvement in adolescent health supervision and involve state agencies, providers of pediatric care, private health insurers, and consumers and has resulted in national recognition. For example, a VCHIP program involving collaboration with VDH is Improving Prenatal Care in Vermont (IPCV) Sets of materials and tools are designed and tested in the IPCV Learning

Collaborative. The state-wide initiative was designed to help improve pregnancy outcomes of low weight and preterm birthrates by implementing updated, evidence-based prenatal care, and developing improved office systems. VCHIP's ADHD initiative (with VDH and Dept of Education) is a multidisciplinary approach to coordinate assessment and treatment of school-aged children with this disorder. VCHIP has added a children's chronic disease focus, providing consultation to FAHC clinical programs for children with endocrine disorders, renal disorders, and cystic fibrosis. VCHIP is a partner in the intended SIG process, for review, redesign, and evaluation for CSHN programs within the larger system of services. In addition, VCHIP continues to partner with CSHN related to SIG and with CSHN Child Development Clinic to implement a practice improvement project. Primary aims of this effort are to provide efficient scheduling and responsive appointments for children and families and reports subsequent to clinic visits.

The Vermont Department of Health works closely with the tertiary care facilities that provide services to Vermonters (Fletcher Allen Health Care in VT, Dartmouth Hitchcock Medical Center in NH, and the Albany Medical Center in NY). Services are provided through the Newborn Intensive Care Units (NICU), the maternity service departments, health service providers through the Healthy Babies system of care and the CSHN programs. In addition, the Regional Perinatal Program (partially funded by Title V) provides training and data analysis to participating birth hospitals in Vermont and New York State. ./2009/CSHN is awaiting final approval of a significant new contractual arrangement with Dartmouth to add a developmental pediatrician and a pediatric psychologist to serve VT children both at Dartmouth and in southern and western Vermont. IN 2010, CSHN began to subsidize a board certified developmental pediatrician and a psychologist at Dartmouth to serve Vermont CDC children on the eastern side of the state.

CSHN continues to provide partnership support to the UVM LEND-ILEHP program, to support training of in-practice professionals in neurodevelopmental disabilities. The CSHN medical director participates in the lecture series. CSHN contracts with ILEHP to provide "Community Clinic" assessments for children with especially complex, community-systems-involved, developmental concerns. ILEHP also hosts an annual week-long conference on the care of children with autism. IN 2010, Vt ILEHP received LEND expansion grant though which training in the ADOS/ADI-R was provided to all CDC developmental pediatricians, nurse practitioners and neuropsychologist, as well as to several community providers, including a pediatrician and 2 psychologists. The LEND autism training grant provided another round of training to VT clinicians in the administration of the ADOS and the ADI-R.

In 2009, Child Development Clinic began to offer experiences for UVM Child Psychiatry fellows. UVM has been approved to offer fellowships beginning 7/09 to expand the capacity of child psychiatry services in Vermont as well as to increase the expertise in caring for children who also have developmental disabilities.

The VDH is represented on Vermont's Interpreter Task Force by Office of Minority Health and Refugee Health Coordinator. This interagency collaboration develops and conducts non-English language interpreter and translator training activities. The task force monitors the need for interpreter services by Vermonters who don't speak English as their first language.

The VDH is represented on the state advisory team on welfare reform and continues to work with the Office of Vermont Health Access and the Department of Children and Families in a variety of initiatives to coordinate programs and activities. Improvements continue to be made to the WIC/Medicaid combined application and eligibility determination process, for example, and VDH and the Department for Children and Families collaborate to improve services and outcomes for parenting teens and their children.

The Vermont Department of Health has collaborated extensively with the Medicaid program in the implementation of the 1115 waiver, in meeting with managed care providers, and in planning for the CHIP benefits expansion.

VDH continues to coordinate efforts with the Department for Children and Families in the Fostering Healthy Families initiative, a program that addresses the health needs of children in state custody. Work between the DCF District Directors and the VDH District Directors is being done to stimulate closer relationships at the local level toward achieving the goal of improving the health of children in state custody.

Another important collaborative relationship exists through the EPSDT School Access program. Each VDH regional office has a public health nurse/school liaison assigned to the task of improving access to health care for school aged children and strengthening the connection between VDH and the schools within their health district.

The VDH works closely with the Vermont Area Health Education Center (AHEC) via contractual and collaborative activities in a variety of statewide and community based projects. The Office of Tobacco Control coordinates with AHEC on provider training re: brief intervention for smoking cessation and collaboration on health care professional workforce issues. AHEC is working on an assessment and intervention tool for providers to use in counseling patients who are obese or overweight. AHEC coordinates the longstanding series of community nursing Grand Rounds -- education sessions are offered 4-6 times yearly via interactive TV for nurses statewide who work in the community (home health, school settings, public health, etc.)

Child Fatality Review Team: is a multidisciplinary team that reviews the deaths of all resident children, ages 0-18, with particular attention to child protection/neglect issues and systems issues that may need to be addressed in order to prevent child and adolescent fatalities. Over the past two years, the Committee has focused on child deaths from all unnatural causes, not just abuse and homicide, such as motor vehicle crashes, suicide, and gun related causes. The team participated in the annual New England wide meeting of CDR teams.

State Agency Coordination for CSHN: CSHN participates in a variety of interdepartmental planning and policy-making settings. CSHN has a particularly close relationship with Medicaid, promoting and assisting eligibility for children, collaboration in the area of prior-authorizations, and reimbursement of CSHN program activities for Medicaid children, through fee-for-service and Medicaid Medical Case. CSHN continues to provide the regional social work staff for the Part C early intervention system (Family, Infant and Toddler Program, FITP) within the Department for Children and Families, and has a seat on the ICC. CSHN is participating in several other AHS-Department of Education initiatives, Act 264 planning; Regional Autism Centers. Individual-child and system-level coordination and planning continue with the Department of Disabilities, Aging and Independent Living (including Medicaid hi-tech program; Personal Care Services; Traumatic Brain Injury project; Developmental Disabilities Services; Vocational Rehabilitation). CSHN MSW's continue to provide consultative support to regional Part C teams and limited targeted direct services. Processing of "payer of last resort" payments for Part C and CSHN is planned for automation for 2010. CSHN continues to work with DCF and OVHA (Medicaid) to facilitate transitioning to automated payment methods for Part C and CSHN will continue to be seamless for dually-enrolled children.

Centralized planning at the AHS has increased in momentum as a result of the passage of Challenges for Change. The planning entered a more concrete phase, with discussion of a common intake, a single electronic record, and a first round of piloting an RFP process for a single budget for 0-6 year olds at the regional level. Subcommittees are being created to address specific integration fronts. One focus is the integration of CSHN with programs are part of the Department of Disabilities, Aging and Independent Living (DAIL), Division of Developmental Services--including the Children's Personal Care Services program, the Bridge Program (regional DS case management, through community-based non-profits), and the Children's Hi-Tech program (in-home nursing for children assisted by technology). Another focus is at-risk children in at-risk environments. Arising separately, but in critical need of connection with CIS/IFS, is the

Autism State Plan and a new legislative mandate to assure that the services needed by individuals with autism are covered by health insurance. As described above, the MCH Director and the CSHN/MCH operations director are key members of the CIS/IFS planning. The Child Development Clinic/CSHN medical director, is involved in the more autism-specific planning. VCHIP and CSHN continue to partner in practice improvement activities in specialty clinics (cystic fibrosis, nephrology, endocrinology), in Child Development Clinic, and in PCP practices.

VDH/CSHN has a longstanding, strong and critically important relationship with the Vermont Family Network. Rather than hiring individuals to serve as program staff, VT has chosen to provide infrastructure support to VFN, to enable it to assess need and provide information and strategic support to a broader range of families than those who seek care from CSHN programs. The partnership allows CSHN, as a funding source, to have input into the priorities of VFN, without disrupting its mission and process, and, in return, provides CSHN with immensely useful information about family strengths, preferences, and needs. CSHN SIG has allowed for expanded support of website development and database integration at VFN. Website improvements are aimed to provide easier access to service information. Database integration at VFN will provide accurate reporting for the definition of gaps in services and act in support of defining future planning needs.

F. Health Systems Capacity Indicators

Introduction

Collaboration with Health Surveillance staff produced 2010 VDH disparities report, using PRAMS, birth data, and infant mortality. SSDI support for the 2010 Title V Strengths and Needs Assessment and the Title V Annual Report. WIC/Medicaid data are matched to Vt resident births. The 2008 birth records were matched to metabolic screening and WIC records. The 2009/2010 birth records have been matched to infant deaths. A report based on the WIC/Birth record match presented to MCH Leadership Team. Programs linking birth files to Medicaid eligibility/claims files revised. MCH surveillance reports produced quarterly. Report on Vt data from 2007 National Survey Children's Health produced. Use of PRAMS survey to evaluate Medicaid match -- PRAMS sample drawn from birth certificate with information on mother's use of Medicaid. Improvements to MCH data reporting for use by MCH staff in the field, such as reporting on smoking prenatal smoking, adequacy of prenatal care, preterm births, etc. Continue with regular PRAMS Data Briefs and MCH Quarterly Reports. Data support will be provided for ACA legislation grant planning such as for teen pregnancy prevention and home visiting supports for at risk families.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.0	17.8	20.3	13.2	13.2
Numerator	79	58	66	43	43
Denominator	32910	32496	32435	32635	32635
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Hospital discharge data for 2009 and population estimates are not available at time of submission. They should be available in late 2010. The 2009 estimate is based on 2008 data.

Narrative:
Overall, though variable due to small numbers, the rate of hospitalization of VT children less than 5 years old for asthma has shown a decrease over the past 15 years, from a high of around 26-27 per 10,000 in 1993 through 1995 to a low of 13 per 10,000 in 2008.

Asthma is a useful indicator of the effectiveness of preventative disease management in both children and adults. Proper access to medical care and quality clinical management of asthma within a medical home can prevent hospitalization and markedly improve the quality of life for children and adults with asthma. The Asthma Program, begun in 2001 (via CDC planning grant) has achieved its initial goals of developing an asthma surveillance system and creating a state asthma plan. The program is designed to improve services to children: 1) Creation of 3 brochures targeting children 0-5, 6-13, and teens, describing how to live a healthy life with asthma. They were distributed to all Vermont physicians, hospital Emergency Rooms, VDH clinics and school nurses. 2) Creation/distribution of Vermont Asthma Action Plan to all pediatricians and school nurses. 3) development/distribution of radio public information spots. 4) Placing resources for parents on VDH website. Pending availability of funds, other activities such as education and support of childcare providers and a QI project for physicians and school nurses will be implemented. Increased surveillance capacity has enabled better data to be obtained from hospital discharge data and emergency department data. Improvements include: obtaining counts of individuals vs. events of hospitalization, analysis of rehospitalizations, and inclusion of a question on the BRFSS about presence of children in the home with asthma. Progress has been made in obtaining data from Medicaid via a report card from the PC Plus population form the Vermont Program for Quality in Health Care. The Behavioral Risk Factor Surveillance System continues to be a valuable tool for measuring asthma prevalence as well as measures of morbidity and treatment-seeking behavior in adults.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	85.7	86.6	88.2	87.4	86.7
Numerator	3148	3174	3301	3420	3166
Denominator	3674	3667	3741	3911	3651
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
In contrast to previous years, data for enrollment in Medicaid during 2004 through 2009 are split out from SCHIP - which is reported separately, below. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

the 2008 report was amended to reflect more complete information.

Notes - 2008

In contrast to previous years, data for enrollment in Medicaid during 2004, 2005, 2006, 2007 and 2008 are split out from SCHIP - which is reported separately, below. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

The 2008 report was updated in 2010 to reflect more complete information.

Notes - 2007
In contrast to previous years, data for enrollment in Medicaid during 2004, 2005, 2006 and 2007 are split out from SCHIP - which is reported separately, below. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

Narrative:
Over the past eight years, there has been a general increase in the percent of VT Medicaid enrollees aged less than 1 year who received at least one initial periodic screen, increasing from around 81% in 2002 to around 87% in 2008-2009.

Vermont's generous Medicaid health insurance enrollment criteria and benefits does not automatically insure that children will receive ongoing health care. Included in Title V measures are those concerning children who received a Medicaid-funded service, infants who received preventative visits, and children (aged 6-9) who
received a dental service. VDH continues updating of the Provider's Toolkit for the dissemination of best-practice guidelines and screening tools to providers of pediatric care -- this toolkit is now "live" on the VDH website. VDH staff work with AAP and AAFP monthly to identify system, policy, clinical or reimbursement issues that might pose a barrier to Medicaid-eligible children receiving routine, high-quality preventive care. Data is guiding the development of this toolkit information -- for example, analysis of injuries to children by age and type of injury give information as to how Vermont children are being injured and how providers and parents can be guided by age-specific information to reduce the risk to their children. Continuing development of provider guidelines that clarify CPT coding procedures for providers to bill for the provision of routine EPSDT screenings. Previously, many services which are actually unbundled from the routine EPSDT visit were thought to be bundled. Clarifying of these procedures was an attempt to facilitate provision of these services. The Medicaid data base capacity assisted in creation of SPM#7: Increase the number of claims submitted by primary care providers to Medicaid for an annual care plan.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	89.7	90.5	92.6	89.8	91.2
Numerator	209	201	175	176	187
Denominator	233	222	189	196	205
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

In contrast to previous years, data for enrollment in SCHIP from 2004, -onwards are split out from Medicaid - which is reported separately, above. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

The 2008 report was updated to reflect more complete information.

Notes - 2008
In contrast to previous years, data for enrollment in SCHIP from 2004, onwards are split out from Medicaid - which is reported separately, above. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

Notes - 2007
In contrast to previous years, data for enrollment in SCHIP during 2004, 2005, 2006 and 2007 are split out from Medicaid - which is reported separately, above. As a consequence, results from 2003 and earlier should not be compared directly to 2004 onwards.

Narrative:
Over the past eight years, there has also been a general increase in the percent of VT SCHIP enrollees aged less than 1 year who received at least one initial periodic screen, increasing from around 78% in 2002 to around 91% in 2009.

Vermont's SCHIP enrollees receive the same benefits as those offered by Medicaid - see discussion HSCI #2

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.7	88.1	87.0	86.6	86.6
Numerator	5228	5329	5186	4922	4922
Denominator	5961	6047	5958	5681	5681
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Vital Records birth data for 2009 were not available at time of submission. They should become available in early 2011. The 2009 estimate is based on 2008 data.

Narrative:
The percent of VT women receiving adequate or intensive prenatal care, based on the older definition of month prenatal care began, increased from around 69% in 1999 to around 88% in 2006. The percentage then declined to 87% in 2007 and 86% in 2008. This trend in the Kotelchuck index was also seen in data based on the new NCHS method for calculating month prenatal care began. A similar slight downturn has been observed in the percent of VT women who started prenatal care in the first trimester (National Performance Measure #18). VDH will

continue to closely monitor these trends, and PRAMS data is being analyzed to identify any new or increased barriers women report to accessing prenatal care.

In 2001, Vermont revised the method used to calculate weeks gestation to better match the methodology used by NCHS. VDH efforts to increase access to medical care for pregnant women, such as prenatal outreach via CIS and WIC and EPSDT, are geared towards continually improving this percentage. Efforts are ongoing to work with birth hospitals to improve accuracy in the count of prenatal visits in the last trimester. Additional work is being completed on the use of provider generated delivery data (OBNET) which will reflect more accurate count of prenatal visitation. PRAMS topic-specific data briefs have been used for Title V Strengths and Needs Assessment and the family planning needs assessment. Other analyses involve SSDI analysis of Medicaid data base and hospital data bases for maternal drug use and infants diagnosed with neonatal opiate withdrawal syndrome used for program planning by VDH and Dept of Mental Health and VCHIP.

Programs providing treatment to pregnant women using illegal drugs have seen a sharp increase in their caseloads; however the programs involved are only seeing women seeking treatment. We've examined the Medicaid database and the hospital databases for drug use and infants diagnosed with drug withdrawal. Although these numbers will not include infants where the symptoms of drug withdrawal are not recognized, and women who are not diagnosed, these numbers did provide an estimate of the broader problem than that seen by the programs' caseloads

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	77.5	77.7	77.6	79.1	81.8
Numerator	57417	56952	55892	57475	60976
Denominator	74056	73312	72007	72640	74587
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

The estimate for the number of children aged 1-21 years who are potentially eligible for Medicaid services is based on the sum of the number of children enrolled in Medicaid at the end of FFY 2009 plus the number of children aged 1-21 with household income <300% of Federal Poverty Level who lacked Health insurance in 2009 (data source VT Banking, Insurance, Securities and Health Care Administration, 2009 Vermont Household Health Insurance Survey). Estimates of uninsured children for 2003 -2008 were based on previous surveys carried out in 2000, 2005 and 2008.

The final 2008 data was revised slightly in 2010 to reflect more complete Medicaid information.

Notes - 2008

The estimate for the number of children aged 1-21 years who are potentially eligible for Medicaid services is based on the sum of the number of children enrolled in Medicaid at the end of FFY 2008 plus the number of children aged 1-21 with household income <300% of Federal Poverty

Level who lacked Health insurance in 2008 (data source VT Banking, Insurance, Securities and Health Care Administration, 2008 Vermont Household Health Insurance Survey). Estimates of uninsured children for 2003 -2004 were based on a previous survey carried out in 2000. Estimates of uninsured children for 2005 -2007 were based on a previous survey carried out in 2005.

The final 2007 data was revised slightly in 2009 to reflect more complete Medicaid information.

Notes - 2007
The estimate for the number of children aged 1-21 years who are potentially eligible for Medicaid services is based on the sum of the number of children enrolled in Medicaid at the end of FFY 2007 plus the number of children aged 1-21 with household income <300% of Federal Poverty Level who lacked Health insurance in 2005 (data source VT Banking, Insurance, Securities and Health Care Administration, 2005 Vermont Household Health Insurance Survey). Estimates of uninsured children for 2003 -2004 were based on a previous survey carried out in 2000.

Narrative:
After a decline in the percent of Medicaid-eligible VT children 0-21 years old who received services from 81.2% in 2002 to 77.5% in 2005, the rate showed an increase again from 2006 though 2009 when it reached 81.8%. This trend will be closely monitored.

Vermont works aggressively to enroll eligible children into Medicaid programs in order to increase the percentage of children who have access to health insurance. Extensive outreach and public information campaigns have been a focus of Vermont's EPSDT program. Outreach for Medicaid enrollment occurs via the VDH district offices, the programs of the Department for Children and Families, and via schools and community organizations that serve families with young children. Age-appropriate information letters are sent regularly to families. Other Medicaid outreach and access activities occur via a statewide central information and enrollment line, website, or via the 211 statewide information line. For a discussion of Medicaid and SCHIP, see Section IIIA and HSCI#2.

Data for tracking this measure are available via Medicaid and the EDS system. The Medicaid data, unlike many other data sources for Title V related analysis, does not reside in the Health Department. A special software license is required to access the data and a required training needs to be completed before access is granted. Up to 10 VDH staff have 'real-time' access to the Medicaid data base.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	66.0	66.6	69.0	66.5	68.8
Numerator	4879	4914	8148	8056	8768
Denominator	7392	7374	11810	12110	12742
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 and 2008 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 61.2%; 2003 = 62.3%; 2004 = 62.5%; 2005 = 65.1%; and 2006 = 68.6%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

Notes - 2008
Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 and 2008 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 61.2%; 2003 = 62.3%; 2004 = 62.5%; 2005 = 65.1%; and 2006 = 68.6%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

Notes - 2007
Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 61.2%; 2003 = 62.3%; 2004 = 62.5%; 2005 = 65.1%; and 2006 = 68.6%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

Narrative:
The CMS-416 data showed a steady increase in the percent of EPSDT-eligible children aged 6-9 years who received dental services, from 59.6% in 1999 to 68.8% in 2009.

The Office of Oral Health continues to promote outreach and the development of a dental home. For activities, see discussion under NPM#9 and SPM #8. In 2009, SSDI analysis of the Medicaid data for the EPSDT/Oral Health program - began as an evaluation of a pilot project at a large pediatric practice targeted to children 3 and under. A dental hygienist was placed in the practice and trained providers to use an oral health risk assessment, and then followed up with families of children determined to be at risk (90% of the children screened) to help them find a dentist who would accept Medicaid if the child did not already have a dentist. The objective of the study was to determine if there was a decrease the number of children with tooth extractions in the pilot project compared to the rest of the state. While no significant differences were found, multiple problems with the evaluation were identified including small numbers, a short follow-up period, an inability to identify the children screened, and it was found that many of the 1-3 year old children already had dental problems at the time of the screening. A broader descriptive analysis of the dental health claims of a cohort of children born in 2001 who were enrolled in Medicaid for at least 95% of the time was performed which included the distribution of age at first visit, and the costs for both preventive and restorative dental care in general and by age at first visit. Findings included that almost two-thirds of the costs were for restorative care.

The results of the oral health study were presented to the Pediatric Council, a committee with representatives from the VT chapter of the American Academy of Pediatrics and the major insurance companies. The finding that two-thirds of the dental costs for young children in Medicaid are for restorative care has lead to interest in providing reimbursement to physicians for providing fluoride varnish.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	45.0	53.3	45.5	46.3	47.1
Numerator	691	866	720	771	793
Denominator	1536	1625	1582	1665	1684
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The denominator for this indicator is derived from Medicaid claims-data of SSI-eligible children under age 16 in FFY2009. The SSI-eligible children were matched to the list of CSHN-enrolled children during the same period. In FFY2009, 1,684 SSI -eligible children received a Medicaid service. 793 of these children were enrolled in CSHN programs, representing 47.1% of SSI-eligible children under 16 years.

Notes - 2008
The denominator for this indicator is derived from Medicaid claims-data of SSI-eligible children under age 16 in FFY2008. The SSI-eligible children were matched to the list of CSHN-enrolled children during the same period. In FFY08, 1,665 SSI -eligible children received a Medicaid service. 771 of these children were enrolled in CSHN programs, representing 46.3% of SSI-eligible children under 16 years.

Data revised in 2010 to reflect updates to Medicaid database.

Notes - 2007
The denominator for this indicator is derived from claims-data of SSI-eligible children under age 16 who received a Medicaid service in FFY2007. This is, of necessity, an under-count of the children who had SSI in that year, some of whom received no services, and some of whom have private insurance that paid for the services they did receive. The SSI children with Medicaid services were matched to the list of CSHN-enrolled children during the same period. In FFY07, 1,582 SSI children received a Medicaid service. 720 of these children were enrolled in CSHN programs, representing 45.5% of SSI-eligible children under 16 years.

Data revised in 2010 to reflect updates to Medicaid database.

Narrative:
Between 2003 and 2009, the percent of children under 16 years and eligible for SSI who received services from CSHN increased by 3%, from 44.1% to 47.1%.

CSHN has made process improvements to capture the information about SSI status of children enrolled in CSHN programs. In addition, we receive information from SSA about children who have successfully applied and received SSI. Their information is reviewed to see if they are participants in a CSHN program, and the information about their new SSI status is available to their CSHN team. The children who are not "in" CSHN but who have received SSI tend to have conditions affecting mental health and behavior. Their information indicates whether they are already participants in VT's children's mental health division program.

As CSHN, with the support of our NFI grant, and, indeed, as the entire Agency of Human Services, encompassing (among others) children's mental health and children's developmental services programs, works feverishly to implement the Children's Integrated Services system within the Integrated Family Services system, a common element is assuring that families have

access to care coordination supports. "Case management" has been identified by the state as one area of service which is not thoroughly implemented, even while most other aspects of EPSDT are. The state has funded (in 2009) a new Bridges case management service statewide to help bridge this identified gap.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	8.4	5.9	7

Narrative:
The comparison of births paid by Medicaid to non-Medicaid births for both 2007 and 2008 (using principle payer field from birth certificate) showed a highly significant difference ($p < 0.001$) for both years.

The difference in outcomes between births paid by Medicaid to non-Medicaid births is believed to be associated, in large measure, with socioeconomic disparities between the two groups. Health disparities amongst Vermont residents were analyzed in considerable depth in a 73-page report published by VDH in June 2010. The report included a set of 26 recommendations that provide priorities for future public health planning and programs.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	6.1	3.4	4.6

Narrative:
The comparison of births paid by Medicaid to non-Medicaid births for both 2007 and 2008 (using principle payer field from birth certificate) showed Medicaid-paid birth outcomes were not significantly more likely than non-Medicaid births to result in an infant death. However, in both years higher infant mortality rates were reported for Medicaid-paid births, and the statistical finding was probably in part due to small numbers.

The difference in outcomes between births paid by Medicaid to non-Medicaid births is believed to be associated, in large measure, with socioeconomic disparities between the two groups. Health disparities amongst Vermont residents were analyzed in considerable depth in a 73-page report

published by VDH in June 2010. The report included a set of 26 recommendations that provide priorities for future public health planning and programs.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	84.3	92.6	89

Narrative:
The comparison of births paid by Medicaid to non-Medicaid births for both 2007 and 2008 (using principle payer field from birth certificate) showed a highly significant difference ($p < 0.001$) for entry into prenatal care in first trimester in both years.

The difference in outcomes between births paid by Medicaid to non-Medicaid births is believed to be associated, in large measure, with socioeconomic disparities between the two groups. Health disparities amongst Vermont residents were analyzed in considerable depth in a 73-page report published by VDH in June 2010. The report included a set of 26 recommendations that provide priorities for future public health planning and programs.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	82.5	89.9	86.7

Notes - 2011
The small discrepancy (0.1%) between HSCI#04 and HSCI#05d is partly due to different age selection of mothers (15-44 years in HSCI#04; no age restriction in HSCI#05d). Also, 10.2% of birth certificates did not report the principle payer - which resulted in these records being excluded from the denominator in HSCI#05d. This in turn led to selection of a slightly different set of records in the two analyses.

Narrative:
The comparison of births paid by Medicaid to non-Medicaid births for both 2007 and 2008 (using principle payer field from birth certificate) showed a highly significant difference ($p < 0.001$) for adequacy of prenatal care as measured by the Kotelchuck index for both years.

The difference in outcomes between births paid by Medicaid to non-Medicaid births is believed to be associated, in large measure, with socioeconomic disparities between the two groups. Health disparities amongst Vermont residents were analyzed in considerable depth in a 73-page report published by VDH in June 2010. The report included a set of 26 recommendations that provide priorities for future public health planning and programs.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	300

Narrative:
Vermont's eligibility for Medicaid and SCHIP are the same at 300% FPL for infants and children up to age 18 years. Pregnant women under 200% FPL are also eligible. For a discussion of Medicaid, SCHIP, and Vermont's Global Commitment, see Section IIIA. See also Section IVE Health Status Indicators.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 21)	2009	 300 300 300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 21)	2009	 300 300 300

Narrative:

Vermont's eligibility for Medicaid and SCHIP are the same at 300% FPL for infants and children up to age 18 years. Pregnant women under 200% FPL are also eligible. For a discussion of Medicaid, SCHIP, and Vermont's Global Commitment, see Section IIIA. See also Section IVE Health Status Indicators.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Narrative:
Vermont's eligibility for Medicaid and SCHIP are the same at 300% FPL for infants and children up to age 18 years. Pregnant women under 200% FPL are also eligible. For a discussion of Medicaid, SCHIP, and Vermont's Global Commitment, see Section IIIA. See also Section IVE Health Status Indicators.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes

Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The first priority of HSCI #9A has been to establish data linkages between birth records and (1) infant death certificates, (2) Medicaid eligibility and claims files, (3) WIC records, and (4) newborn screening records.

Infant death certificates have been matched to birth records since 1979. WIC records have been matched to birth and fetal death records annually since 1996. With support from SSDI, in 2003, Vermont began linking the metabolic screening records and Medicaid birth records to the birth certificate.

The second priority of HSCI #9A has been to establish or improve access to (1) hospital discharge data, (2) a birth defects surveillance system, (3) a Pregnancy Risk Assessment Monitoring System (PRAMS) survey or similar survey, and (4) a Youth Risk Behavior Surveillance System (YRBS) or similar survey. The MCH program is provided with ongoing access to all four of these data systems.

Hospital discharge data are available from the early 1980's for all inpatient discharges from VT hospitals and VT resident discharges from hospitals in New Hampshire, Massachusetts, and New York. Beginning in 2001, an expanded definition of outpatient data, including emergency department visits, has been available from VT and NH hospitals. We have developed agreements with MA and NY to obtain outpatient procedures and emergency department records of VT residents as they become available. VT began collecting data for PRAMS in January, 2001. The VDH has developed Birth Information Network to include infants with special health conditions such as birth defects, hearing loss, metabolic and endocrine conditions and infants born at very low birthweight. In 2005, VDH collaborated with FAHC to expand the capacity of their six hospital OBNet system to directly download birth related data into the VDH birth certificate data system to attain more accurate and timely birth data for such uses as clinical follow up, hospital-specific data, and for public health planning. CSHN is using a CDC cooperative agreement which will extend the OBNet/VDH/CSHN linkage to integrate newborn screening data with prenatal, birth certificate, and immunization data. The Newborn Screening Program receives weekly lists from Vital Records of newly recorded births, which they then compare to their screening records to determine if every infant has been screened, or has a documented refusal. At the end of the year, after the birth files are considered to be complete, the birth records are matched to the laboratory's screening records as a final quality assurance that all infants are being screened. The VDH integrated client management system, is being expanded to link the laboratory screening records to the birth certificate records. The MCH Surveillance Report. produced quarterly, reports on entry into prenatal care, LBW, singleton LBW, pre-term births, small and large for gestational age, teen births and pregnancies, adequacy of prenatal care, and pregnancy smoking and quitting rates.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**

Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
The Youth Risk Behavior Survey is conducted in grades 8 -- 12 every two years. Because of the strong interest in the data available from this survey from both educational and health professionals, approximately 94% of all eligible schools participate

IV. Priorities, Performance and Program Activities
A. Background and Overview

Vermont continues to work toward goals of promoting a comprehensive system of care for its MCH population which includes access to care for both clinical health care and population based services. Along with this goal comes the responsibility to build a comprehensive system of care that is of a high quality and responsive to the needs of the population. VDH has promoted the medical home concept for both medical and dental health care needs. To this end, VDH has worked to establish strong relationships with a myriad of organizations, such as professional groups, hospitals, community-based organizations, home health agencies, schools, and so forth. The VDH's Blueprint for Health (Chronic Care Model) is a specific action plan for these long-standing goals by enhancing the quality of health care and promoting client self-management.

Evidence of success has been revealed though many of the Title V measures and similar data. VDH continues to work at providing support and prevention services to all teens and support services to pregnant and parenting teens. Groups such as the Coordinated School Health Committee and the Fit and Healthy Advisory Committee, are enabling an enhanced collaboration between prevention programs. These programs cover a variety of prevention activities, such as physical fitness, good nutrition, tobacco, drug and alcohol use, mental health and sexual activity, and are broadly aimed at supporting assets in teens and promoting healthy development. VDH planning and assessment is also focused on economic disparities, such as those revealed through the data found in HSCI #5, showing a more negative rates for the measures of low birth weight and rates of prenatal care utilization for women using Medicaid insurance. The 2010 Disparities report also deals with economic, social, racial and educational influence on health status.

Vermont was ranked the second healthiest state in the nation according to the United Health Foundation, together with the American Public Health Foundation and Partnership for Prevention, 2006 America's Health Rankings: A Call to Action for People and Their Communities. Trust for America's Health national report indicates Vermont has the 6th lowest rate of adult obesity (22.1%) and the 9th lowest rate of overweight youths (26.7%) Vermont also ranked second in 2005, both years finishing behind Minnesota. Of all states, Vermont has the lowest percentage of children living in poverty and was also highly ranked for ready access to prenatal care (second best in the nation.) The 2009 Publication of The Health Status of Vermonters compiled by VDH shows that in HP2010 measures, Vermont is doing measurably better than the rest of the nation in 19 areas but still has work to do in the areas of binge drinking and obesity.

Vermont's prevalence of overweight and obese children is unacceptably high and beginning efforts are being put into place to reduce this condition. Programs via WIC (Fit WIC) and school health are directed at parent education and referral for children. Data is also describing the issue of women of childbearing age who are overweight or obese -- strategies to reach this population are in the planning phases. In examining breastfeeding, a related important health measure, NPM #7 indicates that the percent of mothers who are breastfeeding at 6 months is increasing -- the WIC program is implementing a major breastfeeding support program for its mothers.

Vermont's YRBS indicates a significant drop in the percent of students who reported smoking at least once in 30 days, and also alcohol use is declining. Programs in schools, the national QUIT line, and pilot intervention models for physicians' offices are strategies to reduce smoking rates. Also, drug and alcohol use in pregnancy is a renewed priority for Vermont. The state is gradually implementing and expanding its offerings of methadone clinic services. Other efforts include the expansion of the Rocking Horse program is a community based educational support group for low income pregnant/parenting mothers. A 2009 Rocking Horse evaluation indicates significant shift in participants' perception of handling stress more effectively, greater awareness of risk from

drinking during pregnancy, improved parenting, and increase in self esteem.

The Office of Rural Health, with the Vt New Hampshire Bi States Primary Care Assn and UVM College of Medicine, has convened a statewide task to examine the needs and possible actions to address the issue of farm workers safety. Goals are to gather Vermont-specific data to better describe the issue of farm health/safety, to improve access to health care services/medial insurance for farmers and families, support increased farm safety programs, and increase education and outreach for those involved in farm-related occupations. In the Fall, 2008 and Spring 2010, faculty from the University of Iowa presented a 5 day symposium for health care practitioners about the health issues specific to farm workers (arthritis, exposure to toxins, injuries, respiratory problems, etc.) A particular focus on health risks for children was part of the curriculum. Another contributor was the New York Center for Agricultural Medicine and Health.

In 2009, Act 1 passed by Legislature 1/09 in response to a case of a teen girl who was raped/ murdered by a family member June 2008. Much publicity and calls for new laws resulted from this death. Act 1 creates systems changes that strengthen sex offender investigation/prosecution laws. Also requires deliverables such as a tool kit of evidenced based curricula on sexual abuse education required for use in school health education courses, community education/outreach on keeping children safe, education for school and child care staff, and strengthening regulations re: mandated reporters.

B. State Priorities

Vermont's MCH planners and program administrators continue to work and collaborate on state priorities. The MCH planner meets routinely with the SSDI data support analyst and relevant program administrators to investigate meaningful methods of measurement. The final state performance measures are described below and also in Section IVD. The themes of assets and promoting resiliency are also evidenced in planning activities in other state agencies, such as via the ECCS planning, state mental health and alcohol offices, and in the AHS state planning document Vermont Well Being.

The Region 1 Title V leaders continue to be invested in MCH population planning using an assets and resiliency framework. There have been multiple meetings in Boston and conference calls about how to incorporate Lifecourse and social determinants into MCH planning at the state and local level. A Fall 2010 session is planned in Vermont with faculty from BUSPH. The 2010 Vermont Health Disparities Report examines health disparities using framework of educational status, SES, racial/ethnic, etc.

A discussion of the 10 Priority Goals and State Performance Measure follows (See IIIA, IIIB, IIID, and IVD) See 2010 Strengths and Needs Assessment for discussion of the 2010 Priorities.

1. Pregnant women and young children thrive. SPM: % women reporting their pregnancies are intended. According to data from the National Survey of Family Growth (NSFG), in the United States, approximately half of all pregnancies across the age spectrum are "unintended" and may be associated with social, economic, and medical costs. In general, women who lack preparedness for pregnancy are less likely to receive timely prenatal care, and their infants are more likely to lack sufficient resources for healthy development. See NPM 8.

2. Children live in stable, supported families. SPM: % licensed child care centers serving children birth through five years that receive annual visits from a child care health consultant (Common asset based early education indicator for Region 1) To be able to measure the link between comprehensive early childhood systems and the strengthening of assets in young children and

families.. A strong system of early childhood services promotes the health and welfare of children and their families. Region 1 has committed to create a measure that captures this concept within the mission of Title V programs. Nationally, the number of children ages birth to age six in out-of-home care has increased from 30% to over 76% since the 1970's. Thus, it has become increasingly important to be able to evaluate child care programs, to assess quality and accessibility, and to know the impact of care on children's health. Child care health consultants play a critical role in promoting healthy and safe child care environments and supporting education for children (including CSHCN), their families, and child care providers. Child care health consultants also improve access to preventive health services such as medical and dental homes, early intervention and family support. This measure is consistent with recommendations from the AAP, APHA, and MCHB/HRSA.

3. Youth choose healthy behaviors and will thrive. SPM: % youth who did not binge drink on alcohol in the last 30 days. The perceived acceptance of drug-using behavior among family, peers, and society influences an adolescent's decision to use or avoid alcohol, tobacco, and drugs. The perception that alcohol use is socially acceptable correlates with the fact that more than 80% of youth nationally consume alcohol before their 21st birthday, whereas the lack of social acceptance of other drugs correlates with comparatively lower rates of use. For this measure, Vermont is testing the approach of using assets-based wording to measure the absence of binge drinking in youth, so as to emphasize the social and cultural changes that must take place for youth to understand that binge drinking can become the antithesis to the social norm.

4. Women lead healthy and productive lives. SPM: % women ages 18-44 who report eating at least five or more servings of fruit and vegetables per day.
The importance of improving preconceptual health in women of childbearing age has become a priority for health and public health professionals in their efforts to improve birth outcomes. Women need to be supported in certain actions, such as in eating a healthy diet, maintaining a proper weight, getting adequate exercise, avoiding smoking and substance abuse, and obtaining regular health care. One measure of these healthy habits is consumption of adequate amounts of fruits and vegetables. The Folic Acid Education Campaign is planning for the following: 1) Coordinate with the VDH Vermont Eat for Health collaborative to produce educational materials for women and their health care providers. 2) Work with WIC, March of Dimes, and Planned Parenthood to provide a train-the trainer program for health care professionals. 3) Add folic acid information the VDH Eat for Health website. 4) Place videos of folic acid messages in WIC clinic waiting rooms. 6) Provide financial support for DCF to place Folic Acid messages in their Path to Parenthood book. 7) WIC planning to provide vitamin supplements to postpartum/breastfeeding participant at activities geared toward women of child bearing age.

5. Youth successfully transition to adulthood. SPM: % youth who feel like they matter to people (YRBS.) Assets research for youth shows an association between healthy youth behaviors and certain defined assets. VT added 5 asset questions to the 2001 YRBS to gather information on youth assets in relation to youth risk taking behavior. Maine also uses: "Do you feel that in your community, you feel like you matter to people." Region 1 used this approach of assessing population assets in addition to a population needs in the 2005 Title V MCH Needs Assessment. Choosing a youth asset indicator for Priority Goal #5 is viewed as a strategy to operationalize the assessment of youth assets in addition to analyzing youth risk-taking behavior. .

6. Communities provide safety and support for families. SPM: % Vermont cities and towns (population of over 2,000) with at least 1 organized physical activity program in place that is open to all and promoted as a family activity. The Blueprint and the Obesity prevention plan, along with ongoing programs such as WIC, offer several initiatives to encourage communities to enhance residents' health by creating opportunities to be physically active./2010/Over the past year, SPM 6 was aligned with a VDH process of coordinating community based prevention efforts under one framework -- the VDH prevention framework -- that requires comminutes to follow a process of assessment, partnership building, planning, implementation, and evaluation, while emphasizing

evidenced based environmental and policy strategies for increasing physical activity.

7. All children, including CSHN, receive continuous and comprehensive health care within a medical home. SPM: % children under age 16 with SSI whose primary care provider has billed Medicaid for a comprehensive annual care plan. CSHN staff facilitate Medicaid application for CSHN families. VT Medicaid offers enrollment through the TEFRA option to children with the most severe disabilities, regardless of family income. With some reorganization within CSHN, increasing focus on child development activities and relation to the medical home, specific outreach to PCPs to increase their capacity for comprehensive care planning will include: developing/disseminating models for care plans; information about effective billing for care plans; connecting care plans to CSHN enabling services. Promotion of developmental screening within the medical home is a major focus of the VT-AAP chapter, VCHIP, and MCH/CSHN/CDC for the coming year, beginning with the roll-out of the new AAP Bright Futures guidelines through regional meetings to which early intervention and primary care providers are invited. The CSHN NFI grant will support activities particularly in the medical home and financial support of health care outcomes. In addition, our partnership with VFN will continue to support activities in support of improved access to medical homes for CYSHCN. In 2009, NFI includes representation on the steering committee for improvements in developmental screening practices within VT. Medicaid billing codes now reimburse Medical Homes for developmental screens performed at the same time as well child visits. Standardized screening tools will be promoted to implement evidenced based practices according to AAP BF guidelines. Community based referral systems for CIS are nearly complete and will work to improve connections between community providers and medical home. CSHN Developmental Clinic increased referrals as a result of increased developmental screening in the Medical Home and, with SIG support, is striving to coordinate with CIS in order to respond. Note: Support for medical home includes: universal training and implementation of developmental screening, early discussion of Blueprint for pediatric population,, and improving accessibility (to PCP and families) of several programs with care coordination. Also efforts for: integration of care coordination components of CSHN, Developmental Services Bridge program, Hi-Tech, Children's Personal Care services.

8. All children receive continuous and comprehensive oral health care within dental home. SPM: % children using Medicaid who use dental services in one year time period.

The VDH Office of Oral Health works in concert with dental providers to achieve a system which encourages quality dental care as provided in a dental office where comprehensive continuous care can be achieved. Tooth Tutor dental hygienists to provide assessment and referral of students to a local dental home. VDH assists dentists with grants, loan repayments, and recruitment and retention efforts in order to ensure adequate workforce for a dental home.

9. Children and families are emotionally healthy. SPM: % children with emotional, developmental, or behavioral problems requiring treatment or counseling who received needed mental health services in the past year. Children with health insurance, public or private, are more likely to receive the mental health services they need. Of these children needing services who are without health insurance, only 33.8% received any mental health care or counseling. (National rate is 58.7%, NS-CH) Working closely with partners at VCHIP, VDH has assisted in the development of several children's mental health initiatives. A multidisciplinary workgroup that included pediatricians, family physicians, psychiatrists, psychologists, and representatives from public and private mental health agencies working to develop a vision and framework for addressing gaps in the delivery of mental health services for Vermont's children and families. Specific projects include: Vermont's ADHD (Attention Deficit Hyperactivity Disorder) Initiative, through which primary care providers (PCP's) are supported in delivering high quality diagnostic and treatment services to school-age children with ADHD. Treatment plans are developed to target a child's individual strengths and weaknesses, bring together educational and medical interventions, and help eliminate gaps in the child's services or medical care. Plans for pilot projects to place mental health professionals in pediatric offices. This collaborative model links the community mental health agency with physician practices and uses a team approach to assist primary care

providers integrate new processes for mental health services into their practices; gives them the tools needed for screening, diagnosis, treatment and on-going management; and provides psychiatric consultation services to the physician. Medicaid reimbursement for services covers the costs of these interventions. This initiative has increased the number of children receiving services overall and reduced the waiting time for child psychiatry services by several months. Five different pediatric practices in Vermont now have a mental health staff person in their offices in addition to two hours a week of psychiatric consultation. In response to the needs of individuals with autism spectrum disorders (ASD) - Act 35: 2007 legislation requires the creation of an interagency proposal for a coordinated, life-long system of care designed to address the needs of individuals with ASD and their families. 2010 Legislation expanding insurance coverage for children with ASD. CSHN is focusing on the redesign of its Child Development Clinic component, with new support from the MCHB CSHN SI grant. Children with an autism spectrum disorder comprise the largest portion of all children receiving diagnostic services at CDC, a striking increase from one and two decades ago. CDC is now in the 7th year of contracting with a child psychiatrist with special expertise in the care of the children with developmental disabilities, to provide consultation and team-based direct service for children in CSHN as needed. In addition, CDC will begin providing training opportunities for UVM child psychiatry fellows beginning in July, 2009. Note: when this priority was first developed, Mental Health was a division within VDH. In 2009, mental health was reconstituted as its own department. The developmental screening partnership with VCHIP remains within VDH. Current funding for training PCP's in developmental screening will be extended into 2011. CSHN has joined with DAIL to apply for the MCHB SIG for state services for children with ASD. In Vt, the DAIL DS division is the lead entity for planning and services for individuals of all ages who have developmental disabilities, including ASD. There is a significant overlap of populations with CSHN, not well reflected in organizational structure, and improvements in integration and accessibility by families are being planned.

10. Children and families live in healthy environments. SPM: % 1 yr olds screened for blood lead levels. Children are most vulnerable to lead poisoning when they are under six years old, and especially at ages one and two when they normally exhibit hand-to-mouth behavior. The CDC recommends children be screened for lead poisoning at ages one and two years. VT has the second oldest housing stock in the nation - 60% built before 1978 when lead paint was banned. In 2006, the Commissioner of Health and Attorney General established a joint task force to research and evaluate issues surrounding lead poisoning, to develop recommendations for reducing the prevalence of childhood lead poisoning, and to coordinate efforts between VDH and the state and community partners tasked with lead abatement projects. VDH's Childhood Lead Prevention Program (CLPPP) has 3 focus areas: primary prevention, testing and surveillance, case management of lead poisoned children. In 2009, legislation passed: defining Vermont elevated blood lead level as 5µg/dL or greater, sets screening targets for 1 year olds (85% screened) and 2 year olds (75%) that must be met by health care private/public clinical systems by January 2011 otherwise the Commissioner of Health must issue rules to require screening, updates essential maintenance practices, updates requirements for real estate transactions, prohibits unsafe work practices, expands requirements for child care centers in building built pre-1978. VDH is providing training to primary care practices in lead screening so as to meet new statewide screening targets and collaborating with Medicaid about possibility of practitioner reimbursement. Also, VDH is developing system to allow rental landlords and facilities mangers, etc to file compliance statements electronically. Implementing education programs on essential maintenance practices trainings at construction-related courses in high schools and colleges. GIS tracking of neighborhoods with high lead infested housing to guide notification of risk to families living in high risk areas.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	5	7	4	10	
Denominator	5	7	4	10	
Data Source				VT Newborn Screening Program	VT Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data for 2009 are unavailable at the time of submission. They should be available in September 2010.

a. Last Year's Accomplishments
We are gaining in experience with the expanded NBS panel which includes cystic fibrosis. There is a new nurse coordinator for the CF program and the transition
was smooth.
We have a detailed protocol for each condition so that staff coverage in the absence of the NBS chief is manageable. We have expanded our contract with the New
England Newborn Screening Program (UMASS) for consultation.
We continue the seamless transition from positive screen and diagnosis, to clinical follow-up, through CF clinic, Metabolic clinic, and through transfer to similar
clinics in neighboring states as needed.
The NBS chief continues to be in the leadership of NERGG.
We have reviewed the combined NBS fee, for the distribution between metabolic and hearing screening follow-up needs.
We were successful in reclassifying a vacant administrative position to pediatric nurse, to serve NBS follow-up and other clinical functions.
The web-based NBS component of the Child Health Profile database has been activated.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to implement the expanded NBS Panel.			X	X
2. Continue outreach so no baby is lost to follow up	X	X	X	X
3. CContinue seamless transition to clinical care for diagnosed babies	X		X	X
4. Continue cross-border NBS and EHDI efforts.		X	X	X
5. Continue active participation and leadership in NERGG.			X	X
6. Assess program costs as expanded implementation stabilizes, compared with fee based resources and adjust accordingly.			X	X
7. Recruit nurse colleague to expand staff support for program	X	X	X	X
8. Expand access and utilization of web-based NBS database			X	X
9. Establish policy about retention of bloodspot cards			X	X
10.				

b. Current Activities
As above
We are also working on consistent policy about the retention of bloodspot cards and are in active conversation with other states.

c. Plan for the Coming Year
Continue implementation of NBS panel
Continue outreach so no baby is lost to follow up
Continue seamless transition to clinical care
Continue cross border assurances

Reassess program costs and fee structure
Recruit and hire nurse colleague
Expand access and utilization of web-based NBS database
Establish policy about retention of bloodspot cards

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**5957**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	5904	99.1	9	0	0	
Congenital Hypothyroidism (Classical)	5904	99.1	60	5	5	100.0
Galactosemia (Classical)	5904	99.1	3	1	1	100.0
Sickle Cell Disease	5904	99.1	1	1	1	100.0
Biotinidase Deficiency	5904	99.1	1	1	1	100.0
Cystic Fibrosis	4985	83.7	28	2	2	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.4	60	60	65	65
Annual Indicator	57.4	57.4	59.8	59.8	59.8
Numerator					
Denominator					
Data Source				National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	70	70	70	70

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The 2009 estimate is based on the 2005-2006 survey data, which is the most recent survey available.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The 2008 estimate is based on the 2005-2006 survey data, which is the most recent survey available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
We have continued regular meetings with the VFN leadership, even as they have transitioned from interim to permanent directors.
The Hearing advisory council continues to be very active. New parent membership has been recruited successfully.
Child Development Clinic is working with VCHIP on practice improvements including intake and scheduling, in response to family feedback.
CSHN continues significant infrastructure support for VFN.
Through the NFI grant, a Parent Liaison has been hired through VFN, for 20 hours a week, outstationed at CSHN, providing direct support to families referred to her.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue written expectations of family centered care in (direct service) grants and contracts.	X	X		X
2. Continue regular meetings with Vt Family Network (VFN) about child/family needs and all Title V and CSHN issues and policies				X
3. Continue regular meetings with Children's Hearing Health Advisory Council whose leadership and membership includes significant parent representation.				X
4. Continue parent leadership of the NFI and PDSA process.				X
5. Continue significant infrastructure support to VFN		X	X	X

6. Continue position of Parent Liaison		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

As above

In addition, through NFI, the parent director of the health component of VFN has joined the grant team implementing PDSA cycles established at our Jumpstart

NICHQ meeting. These focus on the timeliness and effectiveness of the written reports from Child Development Clinic.

c. Plan for the Coming Year

Continue contractor and grantee expectations for family-centered care.
Continue regular meetings with VFN leadership about all CSHN and Title V issues.
Continue regular meetings with Hearing advisory council
Continue significant infrastructure support to VFN
Continue position of Parent Liaison
Continue parent leadership of the NFI and PDSA process and all NFI activities.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56.5	60	60	60	62
Annual Indicator	56.5	56.5	51.6	51.6	51.6
Numerator					
Denominator					
Data Source				National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	62	65	65	65	65

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. The 2009 estimate is based on the 2005-2006 survey, which is the most recent available.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. The 2008 estimate is based on the 2005-2006 survey, which is the most recent available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The Medical home goals all continue to be relevant. The Medical home and the promotion of its connection with the larger network of health supports for families
of CSHCN is the core of the NFI grant . In support of the Medical Home and its care for children with developmental concerns we are strengthening the capacity of
Child Developmental Clinic statewide and its affiliation with child psychiatry, both through our ongoing teamwork with a contractor child psychiatrist whose
expertise is in children with developmental conditions, and through the training of Child Psychiatry fellows (to begin October, 2010). Our participation in the AHS
CIS/IFS process allows us to advocate strongly for the medical home to be included as central players in each child's care. (see SPM 7).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand capacity of CDC to take new referrals from Medical Homes	X	X		X
2. Continue regional collaboration between CDC and PCPs (e.g. NEAT team)		X		X
3. Continue to advocate for Medical Home centrality to Children's Integrated Services planning and implementation process (See SPM#7)		X		X
4. Continue our CDC based child psychiatry consultation model for children with developmental disability enrolled in CSHN; and, begin training partnership with child psychiatry fellowship program.	X	X		X
5. Track the percentage of CSHN enrolled children with an identified PCP.		X		X
6. Through NFI, explore shift from specialty-centric to Medical Home-centric supports originating in CSHN, and best fit with Blueprint planning		X		X
7.				
8.				

9.				
10.				

b. Current Activities

As above.

Currently, the Blueprint for Health, a model for care of individuals who have chronic conditions, is piloting at three sites serving adults chronic respiratory, cardiac, and/or diabetic conditions. Planning is just beginning for expansion to the pediatric population. The MCH director and VDH commissioner are directly participating.

In addition, we anticipate an increase in referrals from PCPs to CDC as a result of the emphasis on developmental screening in the Medical Home.

The NFI grant is spearheading a major reassessment of the most effective affiliations of CSHN effort. As specialty care providers more often assemble their own teams and are less reliant on public health for their clinical function, public health is able to direct more support to coordination of care with family and medical home. We expect this to be a focus for the coming year.

c. Plan for the Coming Year

Expand capacity of CDC to take new referrals from Medical Homes

Continue regional collaboration between CDC and PCPs (e.g., NEAT Team)

Continue to advocate for Medical Home centrality to Children's Integrated Services in AHS planning process

Continue partnership with child psychiatry and begin training of fellows

Through NFI, explore shift from specialty-centric to Medical Home-centric supports originating in CSHN, and best fit with Blueprint planning

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	68.7	72	72	72	75
Annual Indicator	68.7	68.7	69.4	69.4	69.4
Numerator					
Denominator					
Data Source				National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	75	75	75	75	75

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. The estimate for 2009 is based on 2005-2006 survey data, which are the most recent available.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. The estimate for 2008 is based on 2005-2006 survey data, which are the most recent available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
This year saw the successful achievement of a long-held goal, the streamlining of CSHN accounts payable (for health care) with that of Medicaid. Not all CSHN children have Medicaid, nor are all Medicaid children with special needs enrolled in CSHN. But until now, different payment practices and policies have caused confusion and upset among providers and families alike. CSHN and Medicaid now both utilize a single processing agent, and collaboratively implement prior authorization and medical necessity reviews for shared children.

For families, maintaining Medicaid coverage is as difficult as ever, with failure to pay a monthly prospective premium resulting in loss of coverage for an entire month. Another fragile node in the system is graduation from the 0-18 Dr. Dynasaur program into the less comprehensive state plan and other options for low income young adults. Much of CSHN staff time is spent on patching together coverage for children in the various gaps, while assisting families in understanding the benefits and requirements of the insurances they do have. We continue to purchase insurance for a small number of patients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue, with NFI support, internal (to CSHN practice) and external (interagency and public/private) financial redesign to improve financial access to health care.		X		X
2. Continue to support families in accessing, understanding, and maintaining health care coverage.		X		X
3. Continue to provide infrastructure support to VFN to provide information and guidance to families about health care funding		X		X

4. Continue to assist some families in purchasing insurance		X		X
5. Continue to review, revise and implement changes in CSHN role as a payer of last resort, while maintaining role in assuring access.		X		X
6. Continue to advocate with Medicaid as need arises to for policy clarification or adjustment.		X		X
7. With the expansion of CSHN coverage for hearing aids (up to age 21,) continue to require families(who appear to meet Medicaid income criteria) to apply for Medicaid when applying for CSHN services.		X		X
8.				
9.				
10.				

b. Current Activities

As above.
At the AHS level, the CIS/IFS planning effort also includes revision of some financial arrangements. VT still has a Medicaid waiver, Global
Commitment, which
allows some flexibility and creativity in funding packages. The CSHN/MCH operations director is actively involved in these discussion. The
CSHN medical director is
a participant in a legislative study committee to examine the impact of requiring insurances to cover services for individuals with autism
spectrum disorder.

c. Plan for the Coming Year

Continue, with NFI support, internal (to CSHN practice) and external (interagency and public/private) financial redesign to improve access.
Continue to support families in accessing, understanding, and maintaining health care coverage.
Continue to provide infrastructure support to VFN to provide information and guidance to families about health care funding
Continue to assist some families in purchasing insurance
Continue to review, revise and implement changes in CSHN role as a payer of last resort, while maintaining role in assuring access.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	72.7	75	75	92	92
Annual Indicator	72.7	72.7	89.3	89.3	89.3
Numerator					
Denominator					
Data Source				National Survey CSHCN Chartbook 2005-2006	National Survey CSHCN Chartbook 2005-2006

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. The 2009 estimate is based on 2005-2006 survey daya, which is the most recent available.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. The 2008 estimate is based on 2005-2006 survey daya, which is the most recent available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
This year has seemed a sort of tipping point between old and new strategies for organizing services so that they can be used easily. Traditional Title V strategies have been ways to reduce the distance between families and specialized services, by holding itinerant clinics in multiple locations and by home visiting. More recent strategies have aimed at connecting services, no matter where they are, affording a degree of individualization and family-centeredness that are not possible in a more sole-source-provider model. Several orthopedic sites have closed, with the retirement of their clinicians, replaced by supporting families in accessing tertiary care that is further away for some. At the same time, certain programs have emerged as needing even more of a local presence--Child Development Clinic and physiatry, for example. However, CDC has incorporated in its teams some more local staff, so that when CDC "comes to town"--and leaves--there is still a local team member to follow through. Elsewhere in this report, much mention is made of the AHS Children's Integrated Services planning effort whose goals are also to make services easier for families to access, so there is synergy in mission. Work on the content continues. It is likely that several programs serving overlapping populations will be merged, at least virtually, including CSHN (also Hi-tech, Bridge, Personal Care Services). In addition, autism has become focal point for system design, and CSHN is at that table.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to maintain statewide (and Dartmouth) distribution of CDC clinics and increase capacity	X	X		X
2. Continue to realign clinical staff to provide direct support to families in their regions and clinics and make the "system" usable and accessible for families, and towards connections with medical homes.		X		X
3. Intensify participation in AHS interagency planning for groups especially around ASD; integrate with overlapping programs.		X		X
4. Continue VCHIP practice improvement project with programs serving children with certain chronic conditions (Child Development Clinic; UVM nephrology; UVM diabetes; CF).	X	X		X
5. Continue infrastructure support of regular meetings with VFN to address issues identified through contact with their clients/families.			X	X
6. Continue to collaborate with multiple state agencies, particularly around case management programs and developmental services affecting CYCHCN. Provide leadership of system design (and integration of the "integration.")		X		X
7.				
8.				
9.				
10.				

b. Current Activities

As above.

The pediatric expansion of the Blueprint model has been described elsewhere, but is a model incorporating primary care and connections between internal (in the PCP office) and external (in the community) care coordinators. It is still in the concept phase.

CIS is choosing three regions to pilot a consolidated system approach to early intervention, birth to six, rather than a loose network of linked fee-for-service providers and a host agency.

We continue to draw upon the NFI grant and its NICHQ processes

c. Plan for the Coming Year

Continue to increase capacity and accessibility of CDC

Realign some CSHN staff away from specialty clinics towards community-based connections with medical homes

Intensify participation in interagency planning at AHS, including integration with several overlapping programs

Continue practice improvements with VCHIP in clinics for children with certain chronic conditions (nephrology; CF; diabetes; Child Development Clinic.)

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	5.8	7.5	7.5	55	55
Annual Indicator	5.8	5.8	52	52	52
Numerator					
Denominator					
Data Source				National Survey CSHCN CAHMI website 2005-2006	National Survey CSHCN CAHMI website 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58	58	60	60	60

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. The 2009 estimate is based on the 2005-2006 survey, which is the most recent available.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. The 2008 estimate is based on the 2005-2006 survey, which is the most recent available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
We have strengthened the transition component of the NFI grant through collaborating with VT Family Network around this important goal. The particular focus is
the transition to sources of adult health care. We have also applied for the MCHB State Implementation grant for children and youth with autism spectrum
disorders, with a goal of increasing the capacity of primary care providers serving adults to welcome adults with ASD or other developmental disabilities into their

practices. With the resignation of the NFI grant coordinator last year, representation at Agency of Human Services transition planning and work groups has been
in hiatus, pending a new NFI coordinator. We have continued to provide nutrition, social work and special foods support to young women of child bearing age who
have PKU. CSHN also continues to provide clinical services to adults with cystic fibrosis, through a Department of Medicine pulmonary clinic. financial assistance
with health care costs, and medical social work. In addition, we have expanded the pediatric (and adolescent) physiatry clinic which provides specialty care for
children and youth with physical disabilities with a focus on independence skills. Also, the CSHN medical director continues on the Developmental Disabilities
Council.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue physiatry clinic serving children and youth with physical disabilities	X	X		X
2. The CSHN medical director will continue to participate in the Vt Developmental Disabilities Council, with a focus on the transition subcommittee and transition projects.				X
3. Continue to provide fiscal and social work support to the Vt adults in the adult CF clinic and young women in the metabolic program.	X	X		X
4. When new NFI coordinator is hired, resume participation in AHS transition committees.				X
5. Continue to provide grant support to VFN for their assistance to families and individuals with transition needs.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As above.
Discussed elsewhere in this report is the particularly difficult transition from health insurance available to children and health insurance for the young adult who
has a chronic illness. Continuity of coverage and maintenance of eligibility are challenging to young adults who are newly on their own in every aspect of daily life,
and yet the absence of coverage causes disruptions in care and health status. CSHN's role as a filler of gaps helps to restore continuity once the gap is discovered
--but prevention is the better course. We are hopeful that solving the transition gaps will be part of state health reform efforts, just beginning.

c. Plan for the Coming Year

Continue physiatry clinic serving children and youth with physical disabilities.
Continue services and supports to adults with CF, and women with PKU.
When new NFI coordinator is hired, resume participation in AHS transition committees.

Continue to provide grant support to VFN for their assistance to families and individuals with transition needs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	80
Annual Indicator	83.2	86.1	79.8	74.4	74.4
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	85	85	85	85

Notes - 2009
Data for 2009 is an estimate based on the National Immunization Survey and reflects the 4:3:1:3 :3 schedule for children 19-35 months in 2008. Data prior to 2006 was reported for the 4:3:1:3 schedule, and rates are not comparable. Data for 2009 had not been published by CDC at the time of submission.

Notes - 2008
Data from National Immunization Survey reflects the 4:3:1:3 :3 schedule for children 19-35 months in 2008. Data prior to 2006 was reported for the 4:3:1:3 schedule, and rates are not comparable.

Notes - 2007
Data from National Immunization Survey reflects the 4:3:1:3 :3 schedule for children 19-35 months in 2007. Data prior to 2006 was reported for the 4:3:1:3 schedule, and rates are not comparable.

a. Last Year's Accomplishments
1. District Offices hold monthly iz clinics based on demand and staffing capacity. Intervention primarily needed when there are barriers to accessing the medical home, such as not having medical insurance. Families contacted by phone/letter when due for next Iz.
2. Iz screening and follow up is conducted routinely for all children seen in WIC clinics. Follow up services include assistance in locating a regular health care provider, obtaining the child's most current immunization record from their primary care provider, in understanding Medicaid benefits related to immunization, and transportation assistance. When needed, vaccines are administered

through the VDH District Office and the information is shared with the Primary Care Provider.
3. Ongoing distribution of a one page "Have Your Tots Had all their Shots" flyer, features a simplified immunization schedule and a toll free phone number to reach VDH Iz Program for more information.
4. Ongoing - via EPSDT - Post cards with the most recent immunization schedule mailed to Medicaid parents at 3 months, 8 months, and 20 months reminding them their child was due for immunizations.
5. VDH works with Refugee Resettlement to facilitate Iz and informed consent for refugees.
6. Ongoing distribution of Path to Parenthood to all pregnant mothers - includes section on Iz.
7. Ongoing distribution of Growing Up Healthy, with information on Iz, to all parents while still in hospital after birth of baby.
8. Coordinate with Child Care programs to notify parents when their child is due for Iz. Overall data gathering to assess levels of Iz for children enrolled in day care.
9. Using CASA software, assess 2 year olds in VDH programs - identify and inform parents if their child needs Iz.
10. VDH staff stay informed on Iz topics via a variety of methods, including distance learning (CDC and California DL Health Network)
11. District Offices have been connected to the Iz registry. Many offices have been able to populate the registry with a large percent of their children who are enrolled in WIC.
12. Regular AFIX reporting from provider sites.
13. Continuing incremental increase in the number of children enrolled and practices participating in the Immunization registry.
14. Begin to set process for receipt and distribution of new vaccines, such as Rotovirus.
15. Provider manual created and distributed containing up to date clinical information regarding vaccine administration.
16. Maintenance of immunization section on VDH website and updating with crucial new information.
17. Legislative rules change increasing number of vaccines required for school entry effective as of
August 2008.
18. Completed changes in Vaccine distribution system as of July 1, 2008. VDH Central Immunization Office
takes orders directly from providers and arranges for shipments. Combined state and federal funds pay for vaccine - system is seamless to front line provider.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing immunization clinics held by VDH district offices	X			
2. VFC program ensures universal access to immunizations for Vt children	X		X	
3. COntineu expansion of Vt immunization registry				X
4. EPSDT/HBKF programs for outreach to families provides support for accessing immunization services.	X	X		
5. AFIX program to support clinical practices in increasing rates of fully immunized clients.		X		
6. Coordinate with child care programs and schools to support families to fully immunize their children.	X	X		
7. Implement new legislatively updated list of vaccines required for school entry.			X	
8. New statewide ordering and distribution system incorporating new federal and state financing sources.			X	X
9. Enhanced outreach to physicians to improve rates of fully immunized children.			X	

10. Plan for large scale immunizations of children for H1N1.	X		X	X

b. Current Activities
As listed above and including the following:
1. Offset the recent reduction in Iz rates continues to be a priority for Commissioner and VDH.
2. Analysis of Iz rates to determine specific ares of concern, such as lower rates in specific geographic areas or lower rates of certain vaccines. 3. Enhanced outreach to providers in collaborative effort to increase vaccination rates for
4:3:1:3:3:1 schedule (including varicella)
3. Revision and expansion of immunization information and resources on VDH website.
4. Begin revision of "Have Your Tots Had All Their Shots" materials.
5. Funding assistance to providers to upgrade their refrigeration capacity.
6. Planning for media campaign to parents about importance of immunizations.
7. Planning of outreach to practitioners about how to encourage families to accept vaccination.
8. Planning and implementing of large scale H1N1 Flu vaccination system of public clinics held statewide.

c. Plan for the Coming Year
As listed above and including the following:
1. Continued planning for universal access to vaccines for all Vermonters as legislated by Catamount statute - will benefit adults and children of all ages.
2. Continue to implement new childhood vaccine schedule and outreach to providers in collaborative effort to increase vaccination rates for 4:3:1:3:3:1 schedule (including varicella)
3. Planning for large scale social marketing campaign for providers and parents to increase awareness and acceptance of Iz.
4. Coordination with insurers to expand immunization payment systems.
5. Begin planning and implement large scale vaccination systems for the upcoming flu season.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	7
Annual Indicator	8.1	8.1	8.7	7.4	7.4
Numerator	107	106	113	93	93
Denominator	13248	13153	12971	12536	12536
Data Source				VT Vital Records and VT population estimates	VT Vital Records and VT population estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	7	7	6	6	6

Notes - 2009
Reliable data for 2009 are not available at the time of submission. The 2009 estimate is based on 2008 data. Population estimates for 2009 will be available in November 2010.

Notes - 2008
Reliable data for 2008 are not available at the time of submission. The 2008 estimate is based on 2007 data. Vital statistics for births in 2007 are preliminary, and are subject to change. Population estimates for 2008 will be available in November 2009.

Notes - 2007
Vital statistics for births in 2007 are preliminary, and are subject to change.

a. Last Year's Accomplishments
1. Priority is given to outreach to pregnant teens and their families including: home visits, classes and support groups, transportation to medical appointments, labor support as needed, support with educational needs.
2. The Addison County Parent Child Center focuses on education and support around risky behaviors and pregnancy prevention, in particular targeting high risk teens (both male and female). This is done within the public school environment as well as with teens who utilize PCC services, e.g., teens who have a negative pregnancy test. Similar programs are found in other Parent Child Centers statewide.
3. Teens enrolled in CIS/HBKF are strongly encouraged to finish high school or their G.E.D. and given
support for prevention of second pregnancy.
4. Coordination with organizations such as Parent Child Centers, Department of Education, and Planned Parenthood to support general prevention programs and also education efforts directed at teens considered "at-risk"
5. Coordination with VCHIP, AAP, AHS, and Department of Education on broad prevention efforts using Assets-based approach to working with teens and their families.
6. Support for community and state wide activities to postpone subsequent pregnancies due to higher infant morbidity and mortality rates when pregnancies occur in younger women (15-18) and are spaced less than two years apart.
7. Continue to work with schools and the communities to provide esteem building and future directed programs for teenage girls.
8. Support physical activity initiatives such as Run Girls Run and Fit and Healthy Kids to build esteem and educate importance of personal health.
9. Coordinate with Department of Children and Families to promote pregnancy prevention theme in planning prevention programs for children and adolescents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Services give priority to teens who are parenting and are at risk for subsequent pregnancies.	X			
2. Pregnancy prevention programs for at risk teens via Parent Child Centers, schools, and other community organizations.	X	X		
3. Collaborate with VCHIP, AAP, AHS, and Department of Education on broad prevention programs for all teens, using asset-based approaches.		X		
4. Continue with self-esteem and physical activity programs such as Run Girls Run and Fit and Healthy.	X	X		

5. Maintenance of system of dispensing emergency contraception via collaborative practice protocols.	X			X
6. Collaboration with Planned Parenthood of Northern New England on referrals and services for teen clients.	X			
7. Grant applications from ACA federal funds to create programming and supports for teens st-risk and pregnant/parenting teens to avoid pregnancy until stable life situations.	X	X	X	X
8.				
9.				
10.				

b. Current Activities

Programs as listed above and also the following:
1. Continue with collaboration with Planned Parenthood of Northern New England to increase referrals between client populations.
2. Collaborate with PPNNE on follow up from Family Planning Needs Assessment and Title V Strengths and Needs Assessment.
3. Submission of ACA grants to access federal funds for pregnancy prevention, teen support programs re: risk taking behavior, and establishing evidenced based home visiting programs and strengthening existing home/community programs fr pregnant and parenting teens. .

c. Plan for the Coming Year

Activities as listed above and also the following:
1. Continue with collaboration with Planned Parenthood of Northern New England to increase referrals between client populations.
2. Collaborate with PPNNE on follow up from Family Planning Needs Assessment and Title V Strengths and Needs Assessment.
3. Planning and implementing programs as funded by ACA grants for teens at-risk and pregnant and parenting teens.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	70	71	72	72
Annual Indicator	66.3	66.3	66.3	66.3	66.3
Numerator	271	271	271	271	271
Denominator	409	409	409	409	409
Data Source				2003 Screening	2003 Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	72	75	75	75	75

Notes - 2009
Data is from a one-time non invasive screening of 1,238 children in grades 1-3 in the year 2002-2003. There has not been another screening conducted since that time. Medicaid data indicates there were 2,546 children ages 6-9 years receiving sealants during FFY09. The Medicaid data is not reported as a percentage here due to inability to determine a denominator of Medicaid children of that age group who need sealants.

A new, comparable VT survey was underway at the time of submission, based on a survey tool developed by the Association of State and Territorial Dental Directors and CDC. Results should be available in the Fall of 2010.

Notes - 2008
Data is from a one-time non invasive screening of 1,238 children in grades 1-3 in the year 2002-2003. There has not been another screening conducted since that time. Medicaid data indicates there were 2,263 children ages 6-9 years receiving sealants during FFY08. The Medicaid data is not reported as a percentage here due to inability to determine a denominator of Medicaid children of that age group who need sealants.

Notes - 2007
Data is from a one-time non invasive screening of 1,238 children in grades 1-3 in the year 2002-2003. There has not been another screening conducted since that time. Medicaid data indicates there were 2,227 children ages 6-9 years receiving sealants during FFY07. The Medicaid data is not reported as a percentage here due to inability to determine a denominator of Medicaid children of that age group who need sealants.

a. Last Year's Accomplishments
1. Ongoing collaboration with EPSDT for dental outreach and access to care activities.
2. Ongoing collaboration with Tooth Tutor and fluoride programs (school-based and community water systems). Expansion of these programs as capacity and funding allows.
3. Planning for implementation of the 12 strategies from the Oral Health Plan.
Legislation authorized the "Dental Dozen" initiative and associated state funding. VDH partnered with Office of VT Health Access and Dept of Education to provide a "backpack" message to parents encourging a dental visit as part of routine health care.
4. WIC screening of children and referral to dental services.
5. Collaboration with child care providers to supply education about oral health to their families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC screening and referral of families for oral health services.	X			
2. EPSDT outreach and informing letters and focus on education about benefits of sealants.	X	X		
3. District level planning for follow up to Oral Health Plan and Dental Dozen.			X	X
4. Placement of dental hygienists in a large pediatric office.	X		X	X
5. Placement of a dental hygienist in a VDH district office.	X		X	X
6. Collaboration with PCP's to perform oral health assessments and varnish applications.	X		X	X
7. Medical reimbursement for oral health assessments and varnish applications.			X	X
8. FQHC offering clinical dental services.	X	X		

9.				
10.				

b. Current Activities
Activities as listed above and also the following:
1. Maintain the placement of a dental hygienist in a VDH district office.
2. Collaboration with VDH and AAP to train pediatricians to perform oral health screening of children ages 0-3 years and perform varnish applications. Additional opportunities for training of dental professionals are happening through collaborations with Head Start.
4. Work with Dept of Education, local schools, Medicaid, to inform children and families about the benefits of obtaining age-appropriate sealants for children.

c. Plan for the Coming Year
Activities as listed above and also the following:
1. Placement of a dental hygienist in a pediatric clinical practice.
2. Continue collaboration with VDH and AAP to train pediatricians to perform an oral health evaluation for children under three and counseling with the primary caregiver. Promote the fact that Medicaid
reimbursement for varnish applications for children up to age 5 is now authorized.
3. Distribute educational information to families about the benefits of obtaining age-appropriate sealants for children.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2	2	2	2	2
Annual Indicator	4.7				
Numerator	5				
Denominator	106116	106110	104674	103210	103210
Data Source				Death certificates; VT 2007 population estimates	Death certificates; VT 2007 population estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or				Provisional	Provisional

Final?					
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2	2	2	2	2

Notes - 2009
Vital statistics data for VT 2009 deaths - especially deaths occurring out-of-state - and 2009 population estimates are not yet available. Preliminary data should be available by the end of 2010. The 2009 population estimate is based on 2008 data.

Notes - 2008
In 2008, 2 children aged 14 or younger died due to motor vehicle crashes* in Vermont, a number below the threashold for which rates are to be calculated. The 3-year average (2006-08) is also less than 5. Vital statistics data for VT 2008 deaths - especially deaths occurring out-of-state - are preliminary.

* Traffic accidents only reported. There was one additional death in 2008 due to an off-road ATV accident.

Notes - 2007
In 2007, 3 children aged 14 or younger died due to motor vehicle crashes in Vermont, a number below the threashold for which rates are to be calculated. The 3-year average (2005-07) is also less than 5. Vital statistics data for VT 2007 deaths - especially deaths occurring out-of-state - are preliminary.

a. Last Year's Accomplishments
1. Coordination within VDH and state government and community organizations on car safety issues, such as between VDH (Injury Prevention Advisory Committee) Governor's Highway Safety Council, Child Fatality Review Committee, SafeKids Vermont, VCHIP, etc.
2. Continued development of the injury surveillance plan and surveillance capacity.
3. Reexamine other opportunities for collaboration with the Governor's Highway Safety Program, such as with car crash prevention and, specifically, in education of parents as they instruct their teen children on driving techniques.
4. Information about car seat safety and referral programs via VDH programs such as WIC.
5. Continued distribution of informational booklet for parents of teen drivers.
6. Beginning data analysis of injuries and deaths to children as a result of motor vehicle crashes and other events (such as off road crashes, etc.)
7. VDH grant funded activities for VCHIP to identify and recommend public health policies and also best practices for pediatric providers when counseling teens about safe driving behaviors.
8. Completion of Injury Burden Document with section on deaths due to motor vehicle crashes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate with VDH/state government and community organizations on traffic safety issues.			X	X
2. Continued development in progress of the Vermont State Injury Prevention Plan and Surveillance Plan via the Vermont injury Prevention Program, inclusion of action steps dealing with youth motor vehicle fatality prevention.			X	
3. Childhood injury prevention symposium with topic on motor vehicle crashes October 2009			X	
4. Special data analysis as available from CDC and SSDI funded activity.				X

5. VDH collaborative support of traffic safety programs in schools and communities.			X	
6. Referral of parents to safety seat resources via VDH programs.	X			
7. Collaboration with partners for appropriate legislation such as primary enforcement of seat belt use and texting/cellphone use.			X	
8. VDH participation in the Child Fatality Review Team.				X
9. VDH and partners participating in Children's Safety Network Community of Practice - one topic being that of teen motor vehicle crash prevention.	X	X	X	X
10.				

b. Current Activities

Activities as listed above and also the following:
1. Begin writing of the Vermont Injury Prevention Plan including strategies for reducing injuries to children and teens due to motor vehicle crashes.
2. Passage of legislation re texting and cell phone use for teens primary enforcement for seat belt use.
3. Continued analysis of data describing motor vehicle crashes and resulting morbidity and mortality - use of data in VDH strategic planning and in planning with partners such as the Child Fatality Review Committee, the VDH Injury Prevention Program and SafeKids Vermont.
4. Motor vehicle crashes to be a topic of discussion at statewide child injury prevention symposium October 2009.
5. VDH Injury Program and MCH participated in the New England community of practice sessions sponsored by Children's Safety Network - one topic for action is motor vehicle safety for teens.

c. Plan for the Coming Year

Activities as listed above and also the following:
1. Collaborate with partners to pass appropriate safety legislation, such as further restrictions on texting/cellphone use.
2. Completion of the Vermont Injury Prevention Plan including strategies for reducing injuries to children and teens due to motor vehicle crashes.
3. Continued participation in CSN Community of Practice.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		45	60	60	60
Annual Indicator	42.9	55.3	53.8	59.5	59.5
Numerator					
Denominator					
Data Source				National Immunization Survey - 2006	National Immunization Survey - 2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than					

5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	65	65	65	65

Notes - 2009
The 2009 rate is an estimate based on the provisional 2006 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2009, 2008, 2007 and 2006 rates are therefore not comparable with 2005.

Notes - 2008
The 2008 rate is an estimate based on the provisional 2006 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2008, 2007 and 2006 rates are therefore not comparable with 2005.

Notes - 2007
The 2007 rate is an estimate based on the 2005 rate from the National Immunization Survey. The numerator and denominator were not reported. In July 2007, CDC revised the way that breastfeeding rates were calculated, which are now based on year of child's birth. The 2007 and 2006 rates are therefore not comparable with 2005.

a. Last Year's Accomplishments
1. Continue with Breastfeeding Friendly Employer project.
2. Continue with electric and manual breast pump distribution to eligible WIC mothers.
3. Ongoing community based activities of Breastfeeding Coalition, such as "Baby Showers," educational activities, infant comfort stations at public events, posters, etc.
4. Annual activities for Word Breastfeeding Week, including proclamation from Governor.
5. Continue providing prenatal and postpartum support through the peer counseling program.
6. Updated the breastfeeding section of the VDH WIC manual.
7. Began Loving Support though Peer Counseling in the St. Albans District Office, the third district to begin peer counseling. Includes evening peer support group.
8. Annual breastfeeding symposium with Vermont Lacatation Consultants.
9. Offered "Business Case for Breastfeeding: Creating a Breastfeeding Friendly Environment in Your Community" for VDH staff and community partners. FOcus on four communities - Rutland, Brattleboro, Springfield, St. Johnsbury.
10. WIC attended the FNS regional training in Boston - "Building Breasfeeding Competancies for Local WIC Staff."

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. VDH and partners support of Breastfeeding Friendly Employer programs and provide TA related to new breastfeeding mothers in the workplace legislation.			X	
2. Breastfeeding support programs via WIC such as education, pump distribution, peer counseling, and individual support.	X	X		
3. VDH support of local breastfeeding coalitions.			X	
4. VDH/DCF support of child care services that serve infants and toddlers who are breastfed.		X		
5. Grow and Glow in WIC training for WIC staff on breastfeeding support for WIC clients.	X	X		

6. Collaboration within VDH and with partners to plan action steps for breastfeeding goals of Obesity Prevention Plan.			X	X
7. VDH support of annual Lactation Consultant Association conference and other state/local conferences.			X	
8. Continued maintenance of extensive information about breastfeeding and support programs in VDH website.		X		
9. Exclusively breastfeeding women using WIC receive food package with greatest variety and quantity of foods.	X			
10. New pamphlets on Breastfeeding for IWC clients and also all mothers during their hospital postpartum stay.	X	X		

b. Current Activities

Activities as above and also the following:

1. Grow and Glow in WIC - training staff in breastfeeding support skills presented in local district offices for WIC staff and staff of local community organizations.
2. Annual breastfeeding symposium with Vermont Lacatation Consultants.
3. In previously listed four communities, 32 new employers have been designated as "Breastfeeding Friendly Employers."
4. Breastfeeding trainings to provide CEU's for nurses and lactation consultants - two offerings this past year.
5. Adapted Texas WIC program materials and printed two new pamphlets for breastfeeding families (both WIC and non-WIC families) content deals with new breastfeeding food package and also the breastfeeding hospital experience.

c. Plan for the Coming Year

Continue with activities as listed above with Breastfeeding Friendly Employer designations, WIC staff competancy trainings, conferences, breastfeeding outreach, Grow and Glow.
Insure breastfeeding education and support is contained in any new home visiting programs as funded by ACA grants. Incorporate breastfeeding education more fully into existing statewide home visiting services.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	97	97	98	98	98
Annual Indicator	96.1	96.0	96.3	95.5	95.5
Numerator	5755	5719	5861	5572	5572
Denominator	5986	5955	6088	5832	5832
Data Source				VT Universal Newborn Hearing Screening Program	VT Universal Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	98

Notes - 2009
Hearing screening data for 2009, together with an estimate of the number of occurrent hospital births, were not available at the time of submission. They will be available in January 2011. The 2009 estimate is based on 2008 data.

Notes - 2008
Since this performance measure relates to infants screened before discharge from hospital, only births that occurred in VT hospitals are included in the denominator.

In addition to the 5,572 infants screened before discharge from hospital, 3 home births were screened and 167 infants were followed up and screened after discharge. Overall, 5,742 babies were screened out of a total of 5,957 occurrent births, or a statewide screening rate of 96.4%.

Notes - 2007
Since this performance measure relates to infants screened before discharge from hospital, only births that occurred in VT hospitals are included in the denominator. Vital statistics data for 2007 VT occurrent births remain preliminary at the time of submission.

a. Last Year's Accomplishments
This year we have continued to follow up on a daily basis with hospitals about missed or referred babies. This is a very hand-on process which builds collaborative relationships with the 12 birth hospitals, each of which has somewhat different practices and environments. Our administrative support person has demonstrated remarkable talent in database work as well as skills in phone outreach with families and providers. She has also taken on the responsibility for the "helpdesk" as our web-based information has become available on line to PCPs.
Our audiologist/grant manager has provided new vigor to the Advisory Council, which continues to be the longest-running, consistently productive VDH/MCH/CSHN advisory group--which we attribute to the combined passions of parent and provider members, and to the small size of the community of interest (much smaller than that of CSHCN in general.)

We continue to provide one outpatient site for missed/refer babies to be screened by our audiologist. The site is located in Burlington not only because it is the population center, but also because the birth hospital is the only hospital that does not have its own source of (re)screening. Even the smallest community hospitals have establish reliable rescreening--and reporting-- practices for discharged babies. Community-based audiologists have stepped up also, to accept the role of rescreening babies with at-risk factors.

There continue to be small improvements in the accessibility of ABR diagnosis. An audiologist in Burlington is able to do sleep-deprived ABR, and accepts Medicaid coverage. Our team audiologists have received some training in this technique as well.

There are a few Medical Homes which have accepted TA from the EHDI program around office-based screening; we hope to expand in the coming year.

The EHDI program is perhaps our best example of "moving down the pyramid" of functions, the incremental shifting of direct service to the community, while focusing on assurance, monitoring, and case management.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Continue hands-on, daily interaction with screening hospitals around follow-up of babies, to assure none are lost to follow-up.		X	X	X
2. Continue individual and group TA to screening hospitals, on practices and policies			X	X
3. Continue to assist the audiology practice community in continuing education opportunities			X	X
4. Continue to support the key guidance and leadership of the advisory council.			X	X
5. Continue to implement the objectives of the HRSA and CDC EHDI grants in their third years.	X	X	X	X
6. Expand support for medical home office-based screening.	X	X	X	X
7. Continue transition from primary provision of gap-filling services, to system integrity monitoring, TA, and case management for missed/refer babies.			X	X
8.				
9.				
10.				

b. Current Activities

As above.

A very recent issue has emerged around the funding for specialized early intervention for young children with significant hearing loss and also for those with newly-place cochlear implants. At this writing, the concerns about access to appropriate intensity and quality are unresolved. Although these services have been supported historically by educational sources, we consider it to be a public health issue. We hope to be able to report success, at our regional review.

We have applied for a supplemental grant to expand the capacity of the medical home to perform physiological/objective hearing screening in the office, with a particular emphasis on the some-200 home-birthed babies.

c. Plan for the Coming Year

Continue hands-on, daily interaction with screening hospitals around follow-up of babies.
Continue individual and group TA to screening hospitals
Continue to assist the audiology practice community in continuing education opportunities
Continue to support the key guidance and leadership of the advisory council.
Continue to implement the objectives of the HRSA and CDC EHDI grants in their third years.
Expand support for medical home office-based screening.
Continue transition from primary provision of gap-filling services, to system integrity monitoring, TA, and case management for missed/refer babies.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	3	2	2	2	6
Annual Indicator	5.7	6.9	8.5	6.7	6.7
Numerator	8250	9822	11700	9100	9100

Denominator	143960	143384	137750	135800	135800
Data Source				Kaiser Foundation, State Health Facts	Kaiser Foundation, State Health Facts
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	5	5	5	5

Notes - 2009
Insurance data are unavailable for 2009. They are expected to be published by Kaiser Foundation in March, 2011. The 2009 estimate is based on 2008 data.

3) In 2005, 2008 and 2009, the Vermont Banking, Insurance, Securities and Health Care Administration (BISHCA) carried out a Vermont Household Health Insurance Survey of children 0-17 years old. In 2005, the survey found that 4.9% of VT children (0-17) were uninsured; in 2008 2.9%; and in 2009 2.8% were uninsured. While the age groups used for the two data sources are slightly different, the BISHCA findings appear to be at variance with the Kaiser reports for 2005 and 2008.

Notes - 2008
1) Insurance data for VT are reported from Kaiser Family Foundation State Health Facts. For consistency, the total population estimate reported by Kaiser is used for the denominator even though this number is at variance with the VT population estimate used elsewhere.

2) It should be noted that the age range reported here is 0-18 yrs, not <18 yrs as originally defined for the numerator and denominator.

3) In 2005, 2008 and 2009, the Vermont Banking, Insurance, Securities and Health Care Administration (BISHCA) carried out a Vermont Household Health Insurance Survey of children 0-17 years old. In 2005, the survey found that 4.9% of VT children (0-17) were uninsured; in 2008 2.9%; and in 2009 2.8% were uninsured. While the age groups used for the two data sources are slightly different, the BISHCA findings appear to be at variance with the Kaiser reports for 2005 and 2008.

Notes - 2007
1) Insurance data for VT are reported from Kaiser Family Foundation State Health Facts. For consistency, the total population estimate reported by Kaiser is used for the denominator even though this number is at variance with the VT population estimate used elsewhere.

2) It should be noted that the age range reported here is 0-18 yrs, not <18 yrs as originally defined for the numerator and denominator.

3) In 2005, 2008 and 2009, the Vermont Banking, Insurance, Securities and Health Care Administration (BISHCA) carried out a Vermont Household Health Insurance Survey of children 0-17 years old. In 2005, the survey found that 4.9% of VT children (0-17) were uninsured; in

2008 2.9%; and in 2009 2.8% were uninsured. While the age groups used for the two data sources are slightly different, the BISHCA findings appear to be at variance with the Kaiser reports for 2005 and 2008.

a. Last Year's Accomplishments

1. Distribute Medicaid eligibility fliers to all school aged children with a postage paid return for information request card.
2. Monitor by town and AHS region the number and location of returned cards requesting an application for Medicaid.
3. Continued efforts in working with schools to make health insurance status a component of the school emergency card, thus data can be submitted once per year to the VT Department of Education.
4. Screen all WIC applicants for health insurance status, provide assistance in completing joint application to expedite enrollment in Medicaid/Dr. Dynasaur if interested. All pregnant women, infants and children who meet WIC income guidelines are income eligible for Medicaid.
5. Continue statewide mechanism to follow up with families who were sent a Medicaid application, but who did not apply. The follow up will attempt to both identify possible barriers to applying and assist families in actually applying. Review lessons learned from prior year activities and identify new strategies.
6. Coordinate with state and local agencies to inform eligible clients about rules for new state health insurance programs and new federal requirements for Medicaid.
8. Examine impact of new Medicaid funding system on financing for services to MCH population.
9. Work with DCF to support child care providers to inform their families about potential eligibility for Medicaid insurance.
10. See also NPM #4 for CSHCN

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach to potentially eligible children and families via school nurses.		X		
2. Screening and referral to Medicaid services via WIC clinics and programs.	X	X		
3. Coordinate with DCF to support child care providers o refer eligible families to Medicaid.		X		
4. Coordinate with state and local organizations to inform families about the new state and federal regulations on state insurance programs and Medicaid and also on Catamount/Green Mountain Care.	X	X		
5. Use of newly revised and user-friendly EPSDT informing letter.	X	X		
6. Use of data form School Nurse Health Insurance Survey to assist families with access to medical/dental home.	X	X		
7. See also NPM #4 for CSHCN.	X	X	X	X
8. Collaborate with Medicaid programs to implement new health insurance regulations/programs as authorized by the federal ACA legislation.	X	X	X	X
9. Outreach to providers on new Medicaid and private insurance offerings for children and families as authorized by ACA federal legislation.	X	X	X	X
10.				

b. Current Activities

Activities as listed above and also the following:
1. Tracking of data from school nurses on numbers/percent of students receiving health insurance and who have medical/dental homes.
2. VDH informing families about new Green Mountain Catamount Health Care insurance programs and options.
3. See also NPM #4 for CSHCN
4. VDH planning and coordination with schools and communities to disseminate and act on newly available information about children's access to medical/dental homes. For example, use data to identify children without medical/dental home and work with those families to access care.
5. VDH continue active role in assessing impact of new health care legislation and other changes in health insurances (such as Green Mountain Care) and works via its programs and coalitions to assist families with access to health care services.

c. Plan for the Coming Year
Activities as listed above and also the following:
1. Collaborate with Medicaid programs to implement new health insurance regulations/programs as authorized by the federal ACA legislation.
2. Outreach to providers on new Medicaid and private insurance offerings for children and families as authorized by ACA federal legislation.
3. See also NPM #4 for CSHCN

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	30	25	25
Annual Indicator	30.1	28.7	29.6	29.6	29.6
Numerator					
Denominator					
Data Source				CDC Pediatric Nutrition Surveillance Report - 2008	CDC Pediatric Nutrition Surveillance Report - 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	22	22	22	22

Notes - 2009
2009 data from the Pediatric Nutrition Surveillance Survey was unavailable at the time of submission. An estimate is provided based on 2008 data published by CDC.

Notes - 2008

The 2008 data from the Pediatric Nutrition Surveillance System has been updated in 2010.

Notes - 2007
The 2006 data has been updated to reflect the value of 28.7%. The 2007 data from CDC's Pediatric Nutrtion Surveillance Survey is not available at this writing.

a. Last Year's Accomplishments
1. Ongoing: Screening of every child at routine WIC visits - offering of specialized follow up for those with BMI at or above the 85%.
2. Collaboration with family's PCP for children who are overweight or obese.
3. Nutrition and activity programs such as Fit WIC
4. Myriad of breastfeeding support programs via WIC and community groups - to prevent obesity in early childhood (see NPM #11)
5. Collaborate with DCF on programs supporting good nutrition and physical activity in child care centers.
6. Community physical activity programs as supported via Blueprint and Obesity Prevention Plan (See SPM #6)
7. Development of Eat for Health nutrition information information on VDH website.
8. General nutrition education for families including special events such as nutrition-themed playgroups.
9. VDH staff placed at providers offices in certain regions to provide WIC enrollments and nutrition education services.
10. Develop display boards/videos for VDH district offices with nutrition messages.
11. Ongoing program to to place pediatric residents in District Offices and WIC clinics to learn about community based public health programs.
12. Vt WIC participated in USDA Special Projects Grant entitled "Brighten My Life with Fruits and Vegetables" to increase the offerings of fruits and vegetables to WIC participants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening of every child at WIC visits and offering of specialized follow up for those who are overweight or obese.	X			
2. Collaboration with PCP for those children who are overweight or obese.	X			
3. Nutrition and physical activity programs such as Fit WIC.	X			
4. Breastfeeding education and support programs.	X	X	X	
5. Collaborate with DCF in programs supporting good nutrition and physical activity in child care settings.	X	X		
6. Community physical activity programs as supported by the Blueprint and Obesity Prevention Plan.	X	X	X	
7. Nutrition displays at WIC clinics via display boards and videos.	X			
8. Pediatric provider toolkit "Promoting Healthier Weight in Pediatrics."		X	X	
9. Community grants for nutrition and physical activity initiatives.		X	X	
10. Training in pediatric overweight/obese issues for VDH chronic disease designees.		X	X	

b. Current Activities
Those activities as listed above and the following:
1. Expansion of WIC and Eat for Health nutrition information on VDH website. Include new

information, such as about Folic Acid and Breastfeeding.
2. Provide WIC staff with training on childhood obesity prevention.
4. Completed High Risk Counseling Guide which includes section on childhood overweight with targeted strategies for use with WIC families.
5. WIC/VDH/VCHIP coordination on development and testing of pediatric provider toolkit "Promoting Healthier Weight in Pediatrics" which is on VDH website.
6. Community CHAMPPS grants to develop nutrition and physical activity initiatives for children and families.
7. Coordinate with Atty General's efforts to establish new statewide regulations/recommendations geared for obesity prevention per legislative mandate.

c. Plan for the Coming Year
Those activities as listed above and including the following:
1. Continued expansion of community physical activity programs as supported via Blueprint and Obesity Prevention Plan. Use of physical activity sessions in WIC second nutrition contact.
2. State level staff will provide increased TA and oversight of the follow up activities on all high risk participants, including overweight children.
3. Provide training and TA to VDH chronic disease designees for assessment and planning for nutrition and physical activity programs directed towards families and children at the community level. Project must emphasize policy and environmental changes.
4. Continue coordinate with Atty General's efforts to establish new statewide regulations/recommendations geared for obesity prevention per legislative mandate.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		16	14	14	14
Annual Indicator	16.8	14.8	15.8	17.0	17.0
Numerator	1090	937	996	1050	1050
Denominator	6497	6320	6316	6161	6161
Data Source				VT Vital Records birth certificate data	VT Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	10	10	10	10

Notes - 2009

Vital statistics data for 2009 VT births were unavailable at the time of submission. Preliminary 2009 data should be available in January 2011. The 2009 estimate is based on 2008 data.

Notes - 2007
Vital statistics data for 2007 VT births are preliminary.

a. Last Year's Accomplishments
1. Pregnant women receive screening and referral to Vermont Quit line by private providers and "safety net" providers such as community health clinics and family planning clinics.
2. Vermont Quit Line - telephone counseling service - uses protocol specific for pregnant women as taken from ACOG guidelines.
2. Screening and referral for pregnant women (and for all women) in WIC clinics and via home visiting services.
3. VDH, March of Dimes, UVM and other partners produce report on the best practices for prenatal smoking cessation programs. Plans begin for implementing recommendations. Includes key elements of a research-based program such as incentives for the woman who smokes and use of the "5 A's."
4. New series of TV/radio ads target young women ages 18-28 in lower income groups highlight real Vermont women sharing their personal experiences with smoking cessation.
5. "Wrinkle campaign" - describing effects of smoking on premature wrinkling of skin - targeting young women.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking cessation services specific to pregnant women via the Vt Quit Lie and telephone counseling service.	X	X		
2. Pregnant women receive screening and referral to Vt Quit Line by health care providers, community health clinics, and family planning clinics.	X	X		
3. VDH/March of Dimes/UVM provide TA to community groups by using best practices recommendations of the Perinatal Smoking Cessation Plan.		X	X	
4. Educational materials for women who smoke are distributed by community providers.	X	X		
5. TV/Radio ads focus on smoking cessation for women aged 18-24 who are of lower SE.			X	
6. Giveaways for young women focus on theme of premature wrinkling of the skin.			X	
7.				
8.				
9.				
10.				

b. Current Activities
As listed above and including the following:
1. Continued collaboration with VDH, UVM, March of Dimes to work with community organizations to use recommendations from the Prenatal Smoking Cessation Plan when designing grant-funded cessation programs and projects. Recommendations include best practices such as recall systems, incentives, and breath test monitoring. Example of one such program is the Fresh Start of Baby and Me in Rutland. Analysis of evaluation report.
2. Community coalitions and hospital partners distribute new health education materials directed to women who smoke.

3. Beginning plans for specific programs for pregnant women who smoke - funded by tobacco master settlement. Evaluation of existing programs (in communities and provider offices) and evaluate use of incentives to women to stop smoking.
4. Overall activities to reduce smoking for all ages, such as continued restrictions in smoking in public places (such as outdoor parks) and ongoing education efforts.

c. Plan for the Coming Year
As listed above and including the following:
1. Continue to develop plans for use by communities, WIC and providers' offices using the "5 A's" and adjust according to evaluation report.
2. Planning for activities specifically funded by tobacco settlement for pregnant women who smoke.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	7	4	4	3
Annual Indicator					
Numerator					
Denominator	45801	46163	45733	45231	45231
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	3

Notes - 2009
Vital statistics data for 2009 VT deaths -- especially out-of-state deaths -- are currently incomplete. Preliminary data will be available in January 2011. Population estimates for 2009 will be available in December 2010.
The 2009 estimate is based on 2008 data.

Notes - 2008
Four suicide deaths were reported in 2008, which is below the minimum numerator size for reporting. The 3-year average (2006-2008) was also less than 5.

Notes - 2007
Only three deaths were reported in 2007, which is below the minimum numerator size for reporting. The 3-year average (2005-2007) was also less than 5. Vital statistics death records for 2007 VT deaths remain preliminary at the time of submission.

a. Last Year's Accomplishments
1. EPSDT staff and VCHIP (via grant from VDH to VCHIP) planning for the VCHIP Adolescent Health Initiative which is designed to improve the quality of preventive health services to adolescents.

2. Suicide deaths are routinely monitored by Child Fatality Review Team.
3. VDH collect and monitor data on suicide attempts and completions.
4. Dept Mental Health applied for suicide prevention grant with Center for Health and Learning at Fletcher Allen Health Care. Goals 1) build infrastructure with Vt Youth Suicide Prevention Coalition 2) collaboration with United Way on statewide media campaign to de-stigmatize mental health issues and normalize help seeking behavior 3) develop statewide school and community Gatekeeper training 4) work with VCHIP to implement targeted interventions for college-age students.
5. Vt Injury Prevention program held statewide Child Injury Prevention Symposium in October, 2009, included workshop on child/teen suicide prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. EPSDT/VCHIP collaboration on Adolescent Health Initiative - adolescents are screened for risk and protective factors at preventative health clinical visits.	X	X		
2. Child Fatality Review Team reviews all child/adolescent suicide deaths.			X	
3. VDH collects and monitors data of suicide attempts and completions for MCH and Injury Prevention programs.				X
4. Collaborate with Youth Suicide Prevention Coalition and SAMHSA grant activities.		X		
5. VDH Injury Prevention Program sponsors Child Injury Prevention Symposium Oct 2009 with Youth Suicide Prevention a major topic.	X			
6. VDH Injury Prevention State Plan coordinate with strategic planning by Youth Suicide Prevention Coalition (SAMHSA grant.)	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities
Activities as listed above and the following:
1. DMH and VDH work with VCHIP Adolescent Health Initiative. A major goal is to assure that adolescents are screened for risk and protective factors during preventive health visits.
2. Youth Suicide Prevention Coalition has formed as part of DMH/SAMHSA grant funding. VDH is active partner in the grant's planning activities.
3. Youth Suicide Prevention Coalition providing statewide training for schools and community based professionals on suicide prevention, identification of at-risk teens, and referral to services.

c. Plan for the Coming Year
Activities as listed above and the following:
1. Enhance system for VDH collection and monitoring of data on suicide attempts and completions.
2. Youth Suicide Prevention to be included in Injury State Plan - strategies to be coordinated with Youth Suicide Prevention Coalition.
3. Youth Suicide Prevention Coalition (via SAMHSA grant) providing statewide training for schools and community based professionals on suicide prevention, identification of at-risk teens, and referral to services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95
Annual Indicator	86.3	79.3	92.3	91.0	91.0
Numerator	63	69	60	61	61
Denominator	73	87	65	67	67
Data Source				VT Vital Records birth certificate data	VT Vital Records birth certificate data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

Notes - 2009
Vital statistics data for 2009 VT births were incomplete at the time of submission. Preliminary data will be available in January 2011. The 2009 estimate is based on 2008 data.

Notes - 2008
Level III neonatal facilities where VT resident very low birthweight babies were born in 2008 included Fletcher Allen Health Care (VT) , Dartmouth Hitchcock Medical Center (NH), Albany Medical Center (NY) and St. Peter's Hospital (NY).

Notes - 2007
Vital statistics data for 2007 VT births remain prliminary at the time of submission.

Level III neonatal facilities where very low birthweight babies were born in 2007 included Fletcher Allen Health Care (VT) and Dartmouth Hitchcock Medical Center (NH).

a. Last Year's Accomplishments
1. Assessment of all pregnant women in WIC and HBKF for risk factors of VLBW and offering education and resource referral for prenatal care. Specialized referral for women who may be at high-risk.

2. Collaboration with the Vermont Regional Perinatal Project and the March of Dimes to facilitate the training for perinatal staff in the latest evidenced-based protocols for transport of women in PTL and the transport of infants born in community birth hospitals to regional medical centers.

3. Vermont Regional Perinatal Program has become associated with Vermont Child Health Improvement Program and is now the Vermont Regional Perinatal Health Project. Continues with programs for training and TA to hospital perinatal staff.

4. VDH coordination with Vermont Child Health Improvement Program's Improving Care for

Opioid Exposed Newborns (ICON) for care and services for opiate exposed mothers and newborns - specific communications with select birth hospitals to improve transfer policies and practices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Vermont Regional Perinatal Project to implement activities for training and TA to participating birth hospitals.	X	X		
2. Assessment of all pregnant women in WIC/HBKF at risk for poor pregnancy outcomes and facilitate appropriate referral for high risk prenatal care.	X	X		
3. Collaboration with VCHIP/ICON for QI in services, policies, and procedures for transfer of opioid exposed mothers and newborns.	X	X		
4. Collaborate with VCHIP/ICON for planning of establishment of regional centers of care for opioid exposed neonates and their mothers.	X	X	X	X
5. VCHIP training for hospital/community medical/nursing staff on risks of late preterm births.	X	X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. VDH coordination with Vermont Child Health Improvement Program's Improving Care for Opioid Exposed Newborns (ICON) for care and services for opiate exposed mothers and newborns - planning for certain hospitals to become regional providers of care to neonates of opioid-exposed mothers. This will allow concentrated training for hospital staff in the evidenced based clinical protocols for the care of these mothers and newborns.
2. VCHIP training for community and hospital based medical and nursing staff on risks and follow up care for late preterm newborns.

c. Plan for the Coming Year

Continue with activities as listed above, with a special concentration in the planning activities for the creation of regional centers of care for opioid addicted mothers and also for care of the late preterm newborn.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	92	92	93	94	95

Annual Indicator	89.5	89.4	89.5	89.0	89.0
Numerator	5386	5442	5352	5094	5094
Denominator	6015	6084	5982	5721	5721
Data Source				VT Vital Records birth certificate data	VT Vital Records birth certificate data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

Notes - 2009
Vital statistics data for 2009 VT births were unavailable at the time the report was submitted. Preliminary 2009 data should be available in January 2011. The 2009 estimate is based on 2008 data.

Notes - 2008
For continuity, and to permit comparison with earlier years the NCHS pre- 2003 definition of month prenatal care began was used. When calculated using the new definition of month prenatal care began, 82.5 percent of infants were born in 2008 to women receiving prenatal care in the first trimester,

Notes - 2007
Vital statistics data for 2007 VT births were preliminary at the time the report was submitted.

For continuity, and to permit comparison with earlier years the NCHS pre- 2003 definition of month prenatal care began was used. 83.4 percent of infants were born in 2007 to women receiving prenatal care in the first trimester, calculated using the new definition of month prenatal care began.

a. Last Year's Accomplishments
1. HBKF program staff and program administrators at DCF and VDH manage and facilitate a comprehensive referral system, which puts entry into early and adequate prenatal care as a top priority.
2. Follow-up and outreach is done with individuals through Health Department staff (especially WIC staff) and community home visitors to ensure first trimester connection with a prenatal care provider
3. Contact with providers to facilitate referrals into the HBKF system of care and other services.
4. Office of Rural and Primary Health Care activities to ensure adequate health care workforce in Vermont so as to facilitate pregnant women receiving early and adequate prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State and community programs (WIC/HBKF/CIS) manage and facilitate a comprehensive system of care referral - priority being entry into early and adequate prenatal care.	X	X	X	X

2. VDH works with statewide partners (AHEC, UVM, etc.) to assess and take steps to support adequate OB and pediatric health care providers for each region of the state.				X
3. Outreach with providers to facilitate referrals to the HBKF/CIS systems of care and other appropriate services.	X	X		
4. Outreach and follow up with pregnant women (via WIC/HBKF/CIS) to insure first trimester connection with a prenatal care provider.	X	X		
5. Planning for Integrated Services with HBKF and other DCF services to promote seamless systems of care for pregnant women and children. New system of ACA funded evidenced based home visiting to complement these services.	X	X	X	X
6. Annual review of data from Medicaid, PRAMS, and OBNet to glean information describing the system of care access for pregnant women.			X	X
7. Analysis of disparities for perinatal outcomes as indicated by HSCI #5.			X	X
8.				
9.				
10.				

b. Current Activities

Activities as listed above and also the following:

1. Planning for Integrated Services with HBKF and other DCF services to enhance coordination and promote a seamless system of care for families with pregnant women and young children.
2. Office of Rural and Primary Health Care activities continue activities such as surveillance and provider recruitment to ensure adequate healthcare workforce in Vermont so as to facilitate pregnant women receiving early and adequate prenatal care.
3. Examination of disparities evidenced in Medicaid/non Medicaid perinatal outcomes detailed on HSCI #5.

c. Plan for the Coming Year

Plan for the Coming Year

Activities as listed above and also the following:

1. Continued emphasis on complex systems integration and the planning for Integrated Services with HBKF and other DCF services to enhance coordination and promote a seamless system of care for families with pregnant women and young children.
2. Annual review of data from Medicaid, VDH (PRAMS, BC, etc.) and OBNet to glean information describing
the system of care quality and access for pregnant women.
3. Systems of home visiting as funded by ACA federal grant support at risk pregnant women to receive prenatal care in first trimester.

D. State Performance Measures

State Performance Measure 1: *The percent of Vermont women who indicate that their pregnancies are intended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		70	70	73	73
Annual Indicator	67.6	63.2	66.0	65.5	65.5
Numerator	4271	3929	4128	3928	3928
Denominator	6314	6217	6253	6001	6001
Data Source				VT PRAMS Survey - 2008	VT PRAMS Survey - 2008
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	73	73	75	75	

Notes - 2009
Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. The 2009 estimate is based on 2008 PRAMS survey data. Actual data for 2009 were not available at the time of reporting. They will be available in 2011.

Notes - 2008
Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. The revised 2008 estimate is based on 2008 PRAMS survey data.

Notes - 2007
Estimate is based on data from PRAMS survey of women who have recently given birth to live infants. This estimate does not include pregnancies that end in abortions or fetal deaths. The revised 2007 estimate is based on 2007 PRAMS survey data.

a. Last Year's Accomplishments
1. Assessment of women's reproductive health needs and referral as needed to providers of family planning services. Assessment performed by staff in state service programs, such as WIC, Healthy Babies, Kids, and Families, and by community organizations such as Parent Child Centers and Home Health Agencies.
2. State program coordination with family planning service providers such as Planned Parenthood of Northern New England and Community Health Centers.
3. Public education about availabilty and use of family planning methods via brochures and websites. Information availagle in a variety of languages.
4. Community based teen pregnancy prevention programs for pregnant and parenting teens and teens at risk of pregnancy and their male partners - via schools and Parent Child Centers.
5. VDH support of system as created by 2006 law Act 101 which allows Emergency Contraception to be available to women at pharmacies via formal Collaborative Practice agreement with Prescribers. Statewide CEU conference for pharmacists - attendance at this conference was required for pharmacists to participate in collaborative practice for dispensing of emergency contraception medication.
6. Beginning conversations with Planned Parenthood of Northern New England to incorporate assets approach to women's well care visits.
7. Sexuality education offered in schools to increase student knowledge about reproductive health and methods of birth control.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Assessment of women's health care referral needs and referral to providers of family planning services. Assessment performed by staff of programs such as WIC, HBKF, CIS, PCC, HHA	X	X		
2. State programs coordinator with family planning service providers such as Planned Parenthood of Northern New England and FQHC.		X	X	X
3. Public education about the availability and use of family planning methods via brochures, websites, etc. Information available n a variety of languages.	X	X		
4. Community based teen pregnancy prevention programs for pregnant and parenting teens at risk of becoming pregnant and their partners - via schools, Parent Child Centers, etc.	X	X		
5. PRAMS analysis of women's health experiences during pregnancy and postpartum informs public health and community response.				X
6. Pharmacists dispensing of EC via collaborative practice to teens under age 16.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

Activities as listed above and the following:
1. VDH Division of MCH and Office of Local Health increasing collaboration with Planned Parenthood of Northern New England to enhance referral of mutual clients for reproductive health services.
2. VDH/EPSDT school health partnership supporting use of school wellness exams that encourage practitioners to use AAP Bright Futures guidelines in sexuality teaching for youth and their parents.
3. SSDI support for PRAMS data analysis of health behaviors of women during pregnancy and postpartum - data will be used for planning and to refine programs to better assist pregnant women during their pregnancies and in general for health programs to support women during their childbearing years.

c. Plan for the Coming Year

Activities as listed above and the following:
1. Collaboration with PPNNE for planning as result of the Title X program requirement for Family Planning needs assessment and the Title V MCH assessment.
2. Work with Medicaid to impement new regulations from 2010 ACA legislation allowing low-income women to access family planning and be eligible for Medicaid reimbursement.

State Performance Measure 2: *The percent of licensed child care centers serving children age birth to five who have on-site consultation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Performance Objective		60	60	63	63
Annual Indicator	57.3	18.4	16.2	16.2	16.2
Numerator	243	75	66	66	66
Denominator	424	408	408	408	408
Data Source				Program data	Program data
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	

Notes - 2009
SPM 2 is designed to measure the percent of on-site visits by child care health consultants - which is reported here as 66 visits with 10 out of 12 districts reporting. Due to staffing shortages, other methods of child care health consultation are being emphasized in addtion to site visits, such as phone visits and regional inservice sessions. In 2008, due to budget and staffing cuts, the capacity to carryout this program's activities was severly hampered. Thus, the data reported is the data for 2007. Evaluation of program capacity and appropriateness of the SPM for the next year is presently taking place.

Notes - 2008
SPM 2 is designed to measure the percent of on-site visits by child care health consultants - which is reported here as 66 visits with 10 out of 12 districts reporting. Due to staffing shortages, other methods of child care health consultation are being emphasized in addtion to site visits, such as phone visits and regional inservice sessions. In 2008, due to budget and staffing cuts, the capacity to carryout this program's activities was severly hampered. Thus, the data reported is the data for 2007. Evaluation of program capacity and appropriateness of the SPM for the next year is presently taking place.

Notes - 2007
SPM 2 is designed to measure the percent of on-site visits by child care health consultants - which is reported here as 66 visits with 10 out of 12 districts reporting. Due to staffing shortages, other methods of child care health consultation are being emphasized in addtion to site visits, such as phone visits and regional inservice sessions.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
1. A web-based data system was developed so the CCHCs could enter their time spent on consultation and training.
2. Health and safety consultation to licensed and registered child care programs; limited capacity re: time and number of staff available due to funding restrictions
3. Group trainings were provided in each district on infectious disease and the importance of immunizations in the child care setting,
4. Trainings provided through VT's Early Childhood Professional Development System: Northern Lights Career Development Center. Topics include healthy environments and health needs, safe environments, nutrition and physical activity.
5. Statewide CCHC meetings for program consistency, CCHC training topics, child care quality and systems, ECCS/Building Bright Futures
6. Consultation to VT child care licensors on health and safety topics

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnering with Halthy CHild Care NEw England to support ongoing trainings for child care health conslatnts.		X	X	
2. Collaboration with ECCS/VDH o early chld care systems issues and solutions.			X	X
3. Support for continued Touchpoints trainings for childcare providers.		X		
4. Maintenance of web-based data system to document activities of child health care consultnats.				X
5. Building of community coalitions to support quality child care and early education via ECCS grant systems.			X	X
6. Planning for prioritizing CCHC services as able to be offered due to funding restrictions and staff cutbacks. Consideration of offering services n a limited format via other venues.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

b. Current Activities

Activities as listed above and also the following:

1. Maintenance of the web-based data system for CCHCs to enter their time spent on consultation and training.
2. Continuing with reduced services for health and safety consultation to licensed and registered child care programs - capacity continues to be very limited due to funding restrictions and staff reductions.
3. Purchase of 640 copies of Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide, (AAP, 2nd Edition) with ECCS funds and distributed them to licensed and registered child care programs around the state through VDH. Possible purchase of same Reference for school health nurses.
4. Review and edits to update the health and safety sections of the VT's Early Childhood Licensing Regulations, currently undergoing the rules promulgation process
5. Concern for continuation of the Child Care Health Consultant program in its present form due to state budget issues and staffing reductions. Alternatives to reaching the program goals of education and TA to child care providers are being considered at this writing.

c. Plan for the Coming Year

Concern for continuation of the Child Care Health Consultant program in its present form due to state budget issues and staffing reductions. Alternatives to reaching the program goals of education and TA to child care providers are being considered at this writing. Work with child care systems via ECCS and opportunities presented by ACA legislative funding to strengthen programs for health consultation to child cares.

State Performance Measure 3: *The percent of youth who do not binge drink on alcoholic beverages.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		80	82	82	85
Annual Indicator	78.6	78.6	77.0	77.0	79.7
Numerator	31347	31347	29744	29744	29357
Denominator	39891	39891	38641	38641	36839
Data Source				YRBS Survey - 2007	YRBS Survey - 2009
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	85	85	85	

Notes - 2009
Weighted data for 2009 are based on a YRBS survey carried out in the same year.

Notes - 2008
The YRBS survey is carried out biennially. The estimate for 2008 is based on a YRBS survey carried out in 2007. .

Notes - 2007
Weighted data for 2007 are based on a YRBS survey carried out in the same year.

a. Last Year's Accomplishments

a. Last Year's Accomplishments
1. EPSDT staff have worked closely with Vermont Child Health Improvement Project (VCHIP), an organization designed to work with physicians to improve the quality of preventive health services to adolescents. Collaboration to set guidelines for well-adolescent visits for screening for risks/assets to determine potential for alcohol use and abuse. Use of CRAFFT. Guidelines for discussion of assets with teens and their families.
2. Screening and education for prenatal alcohol use via the WIC/Rocking Horse collaboration.
3. VDH Office of Drug and Alcohol Abuse programs and community based New Directions grants are targeted to the prevention and reduction of underage substance abuse. In FY08, 15 coalitions received funds to support capacity building and implementation of evidenced based practices.
4. Underage drinking initiatives such as Stop Teen Alcohol Risk Teams (START), Alcohol Awareness month, public education about underage drinking and providing opportunities for dialogue (town hall meetings)
5. Vt Drug and Alcohol Information Clearing House provides information to communities, schools, service providers and the general public.
6. 10 Regional Prevention Consultants offer a variety of services to communities to address alcohol and other drug prevention: services include program planning, information, training, consultation and community organization.
7. The FACES (Families & Adolescents driving Care for Effective Services) Project is a collaborative effort to get parents and teens involved in helping shape teen substance use and mental health services across Vermont. The FACES Project is working towards expanding and developing regional groups of family members to help redefine Vermont's adolescent treatment system.
8. In FY08, 23 community coalitions received funding under the Strategic Prevention Framework, State Incentive Grant (SPF/SIG) to support a strategic planning process to address the priorities of reduction in underage drinking, reduction in high-risk drinking in persons under age 25, reduction of marijuana use among persons under the age of 25 and building prevention capacity and infrastructure. Grantees focused on assessment and capacity building.
9. VDH Division of Alcohol and Drug Abuse Programs provided funding for 100 high schools and middle schools to support Student Assistence Programs (SAPs.) SAPs provide prevention education, screening, referrals, training and consultation.

10. Implemented the "Question the Message" common theme campaign to prevent underage drinking. The campaign allowed for a consistent and focused messaging throughout the state targeted to youth aged 12-15.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VDH/EPSDT work with VCHIP to design and implement screening guidelines for teens on drinking and asset/rick behavior.	X	X	X	
2. Prenatal alcohol use prevention/intervention programs	X	X	X	
3. New Directions community grants for alcohol prevention	X	X		
4. Strategic Prevention framework State Incentive Grant activities		X	X	X
5. Underage drinking initiative - START - and public education programs.	X	X	X	
6. Vermont Alcohol and Drug Information Clearinghouse	X	X		
7. Regional Prevention Consultants	X	X		
8. Adolescent Alcohol and Drug treatment grant	X	X	X	X
9. Explore new initiatives for asset promotion and changing culture of teens and alcohol use/abuse.		X	X	
10. FACES Project implementation.		X		

b. Current Activities

b. Current Activities

Activities as listed above and also the following:

1. VDH Division of Alcohol and Drug Abuse Programs partnered with VCHIP to redesign and distribute a substance abuse prevention brochure targeted to parents of adolescents. The brochure provides information on three important steps that parents can do with their teens to help reduce the likelihood they will use alcohol and other drugs. The materials will be distributed through primary care providers participating in the Youth Health Initiative.
2. 23 SPF/SIG grantees received funding to continue assessment and capacity building. Grantees also began to develop implementation plans for addressing goals of reducing underage drinking, reducing high risk drinking among persons under age 25 and reducing marijuana use in persons under age 25.
3. Six community coalitions have received New Directions grant funds to support the prevention and reduction of underage substance abuse, capacity building and implementation of evidence based practices.

c. Plan for the Coming Year

Activities as listed above and also the following:

1. The Division of Alcohol and Drug Abuse Programs will support 23 Vermont communities with SPF/SIG grant funds to strengthen and maintain substance abuse prevention services throughout the state.
2. Implement two "Common Themes" campaigns targeting parents of youth ages 12-17. The goals of the campaign are to increase awareness of resources available to parents of middle school youth and to increase awareness among high school parents about the negative consequences of underage drinking for them and their children.
3. Strategic planning on how to connect prevention, intevention and treatment initiatives through

the Recovery Oriented System of Care (ROSC) process.
4. Partner with a community organization to manage the Vt Alcohol and Drug Information Clearinghouse (VADIC.) This will increase access to alcohol and other drug resources including brochures, posters, and DVD's.

State Performance Measure 4: *The percent of women of childbearing age who consume at least two servings of fruit and three servings of vegetables daily.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		34	35	35	38
Annual Indicator	33.5	33.5	35.0	35.0	33.1
Numerator	37726	37726	38680	38680	34126
Denominator	112736	112736	110600	110600	103223
Data Source				BRFSS Survey - 2007	BRFSS Survey - 2009
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38	38	38	38	

Notes - 2009
Weighted data based on 2009 BRFSS survey of VT women 18-44 years. Note that BRFSS question does not differentiate between fruit and vegetable servings. Numerator reported is population estimate for women 18-44 years who reported eating 5 or more servings of fruits and vegetables, combined.

Notes - 2008
The 2008 estimate is based on 2007 BRFSS survey of VT women 18-44 years. The BRFSS fruit and vegetable survey questions are only asked in Vermont every other year. Weighted data for 2009 will be available in February 2010.

Note that BRFSS question does not differentiate between fruit and vegetable servings. Numerator reported is population estimate for women 18-44 years who reported eating 5 or more servings of fruits and vegetables, combined.

Notes - 2007
Weighted data based on 2007 BRFSS survey of VT women 18-44 years. Note that BRFSS question does not differentiate between fruit and vegetable servings. Numerator reported is population estimate for women 18-44 years who reported eating 5 or more servings of fruits and vegetables, combined.

a. Last Year's Accomplishments
1. State level CHAMMPS grants awarded to 9 communities. They are focusing on policy and environmental change for healthy choices. Activities include increasing access to fresh fruits and vegetables via farm to school programs, working with a local food shelf to offer produce from farmers and community gardens, and creating new community gardens in underserved areas.
2. Farm to school grants awarded to four schools for planning and seven for implementation. Farm to school integrates the program in the community, classroom and cafeteria increasing children's exposure and acceptance of new fruits and vegetables.
3. Updated the state nutrition wellness policy guidelines for nutrition standards for foods served and sold in schools outside of the school meal program.

4. Applied for and received funding for the development of a Healthy Retailer project.
5. In partnership with the Alliance for a Healthier Generation conducted two regional trainings on school wellness policy implementation.
6. Dissemination and training of provider practices on the use of the pediatric obesity prevention toolkit.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Women in WIC are offered education about fruit and vegetable consumption and supports such as Farm to Family coupons and EBT WIC card for purchase of fruits and vegetables.	X	X		
2. School based programs such as health classes, food services, and other courses offer education to children and youth about the importance of fruits and vegetables.	X	X	X	
3. Collaboration with DCF/ECCS to support child care providers to promote fruits and vegetable consumption with the children and mothers who use their services.	X	X		
4. Coalition with advisory committee for Vermont Obesity Prevention Plan on objectives relating to provide diet and nutrition.			X	X
5. Folic Acid education about food sources in WIC clinics and offering a supply of multivitamins.		X		
6. Nutrition training for WIC and community health workers.		X		
7. Collaboration with state agencies on implementing recommendations/guidelines as detailed n 2008 legislation.			X	X
8. Maintenance of media campaign for Eat for Health website.		X		
9. Collaboration with Governor's Task Force on Hunger to create recommendations and implementation of initiatives.		X	X	X
10. Collaboration and activities around worksites, schools, and communities via H.887.	X	X	X	X

b. Current Activities
1. Ongoing partnership and participation in the state Farm to School Network.
2. Governors Hunger task force working towards implementation of recommendations to increase access to nutritious food for all Vermonters.
3. Adding a Farm to Family coupon for produce at farmers markets for women enrolled in the Ladies First cardiovascular disease risk reduction program.

c. Plan for the Coming Year
1. VDH is planning to partner with the Department of Children and Families to enhance licensing requirements for early childcare o support healthy eating and physical activity.
2. Developing a Healthy Retail store designation for retailers who offer and promote healthy choices including fruits and vegetables and limiting the promotion of tobacco and alcohol.

State Performance Measure 5: *The percent of youth who feel like they matter to people.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		45	48	48	50
Annual Indicator	44.6	44.6	47.4	47.4	46.5
Numerator	17630	17630	18192	18192	16262
Denominator	39538	39538	38355	38355	34936
Data Source				YRBS Survey - 2007	YRBS Survey - 2009
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	

Notes - 2009
Weighted population estimate based on YRBS survey carried out in 2009.

Notes - 2008
The YRBS survey is carried out biennially. Data for 2008 is based on the weighted population estimate from the YRBS survey carried out in 2007.

Notes - 2007
Weighted population estimate based on YRBS survey carried out in 2007.

a. Last Year's Accomplishments
1. School Health curricula and programs dealing with development of self esteem and confidence building. Anti-bullying and anti-racism education programs required to be taught in the public schools by state legislation.
2. School and community mentoring programs via schools, Boys and Girls Clubs, Boy/Girl Scouts, 4H, faith based groups, etc.
3. Substance abuse/Drug and and Alcohol prevention programs via schools and community based grants - refer to SPM 3.
4. Vermont Child Health Improvement (VCHIP) project development of positive youth development materials for teens and parents of teens - such as adolescent emotional development assessment tool designed to be used by primary care providers in youth "well child" visits.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Support of school health curricula and programs dealing with development of self esteem, such as anti-bullying and anti-racism programs.			X	
2. Support of school and community mentoring programs.			X	
3. VCHIP development and distribution of positive youth development development educational tool for providers, youth, and parents.	X	X		
4. Support of substance abuse/drug and alcohol prevention programs.	X	X		
5. VCHIP initiatives to improve screening, referral, and access to services dealing with youth and mental health needs.	X	X	X	
6. EPSDt/School Wellness exam requirements encouraging use of Bright Futures and mental health wellness in anticipatory guidance.	X			
7. Education in schools about sexual assault and prevention according to regulations in Act 1.	X			

8. Youth Suicide Prevention Coalition statewide education activities in schools and communities.	X	X	X	
9.				
10.				

b. Current Activities

Activities as listed above and also the following:
1. VDH participation in Youth Suicide Prevention Coalition activities resulting form newly obtained SAMHSA grant. Major activities are training of school personnel, students and community members about recognizing the signs of suicide in youth and how to respond.
2. VDH participation in planning and implementation of educational activities related to Vermont Act 1 - designed to educate students and school personnel about sexual assault and violence and its prevention.
3. EPSDT/Schoolhealth collaboration encouraging use of Bright Futures guidelines in wellness exams - guidelines for anticipatory guidance and assessment of child development and mental health.

c. Plan for the Coming Year

Activities as listed above and the following:
1. Incorporation of youth suicide prevention action steps in the plannined revision of the Vermont State Injury Prevention Plan.

State Performance Measure 6: *The percent of Vermont towns (population of 2,000 or more) who have at least one organized physical activity program in place that is open to all and promoted as a family activity*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35	40	40	45
Annual Indicator	40.7	40.7	40.7	40.7	40.7
Numerator	35	35	35	35	35
Denominator	86	86	86	86	86
Data Source				Program data	Program data
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	

Notes - 2009

This objective has been aligned with VDH process of coordinating community based prevention efforts concentrating on program implementation. Recently the emphasis has changed to support ing a broad public health planning process that includes needs assessment and evaluation in additon to implementation. Thus data for this measure is no longer being gathered. An appropriate new measure will be considered for the 2010 TV Strengths and Needs Assessment.

Notes - 2008

This objective has been aligned with VDH process of coordinating community based prevention efforts concentrating on program implementation. Recently the emphasis has changed to support ing a broad public health planning process that includes needs assessment and evaluation in additon to implementation. Thus data for this measure is no longer being gathered. An appropriate new measure will be considered for the 2010 TV Strengths and Needs Assessment.

Notes - 2007

This objective has been aligned with VDH process of coordinating community based prevention efforts concentrating on program implementation. Recently the emphasis has changed to support ing a broad public health planning process that includes needs assessment and evaluation in additon to implementation. Thus data for this measure is no longer being gathered. An appropriate new measure will be considered for the 2010 TV Strengths and Needs Assessment.

a. Last Year's Accomplishments

As guidance from the Centers for Disease Control and Prevention (CDC) has been shifting to a much stronger emphasis on the "built environment" and policy level changes for increasing levels of physical activity, so has the direction of the Vermont Department of Health's (VDH) Fit and Healthy Vermonters community based physical activity programs. As a result, over the past year, VDH communities have been shifting their focus from "organized" physical activity programs, such as a walking programs, to the "higher level" strategies of policy and environmental change. Examples of these are enhancing access to parks, improving recreation paths or sidewalks, establishing farmers markets in communities, creating worksite or school policies that support healthy foods being offered in vending machines or snack carts. Furthermore, the Fit and Healthy Vermonters program has a coordinated approach so, in addition to communities, schools, worksites, health providers, and state partners all receive messages, resources, technical assistance on policy and environmental strategies for obesity prevention complimenting and increasing the impact of the work being done in communities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State and local planning for implementation of school and community physical activity programs related to Blueprint for Health and the Fit and Healthy Vermonters Obesity Prevention Program.	X	X	X	X
2. Support of existing programs to promote physical in children such as Fit WIC, SPARK, Girls on the Run, etc.	X	X		
3. Support of communities as they develop a variety of walking and other physical activity programs.	X	X		
4. Funding for further community infrastructure projects via Safe Routes to School.				X
5. Participation i follow up to the Healthy Lifestyles components of H.887 by researching evidenced based programs and education of policymakers.			X	X
6. Governor's Daylight Savings Challenge programs designed for year round activities.	X	X		
7. Get Moving Vermont website to be used for physical activity team activities and individual goal success.	X	X		
8.				
9.				
10.				

b. Current Activities

1. Fit and Healthy Vermonters program provided support and guidance to 18 (CHAMPPS and Blueprint) community coalitions working toward improving community environments to make them conducive to physical activity and healthy eating. This included sharing methods and tools for building partnerships, performing assessments for community based prevention needs, planning, and implementing evidence based strategies.
2. In 2010 Vermont's Attorney Generals' office initiated an Obesity Prevention project to examine how they can support the state's obesity prevention activities. VDH staff have been playing an active role consulting on this project.
3. Fit and Healthy Vermonters (in partnership with Vermont's Action for Healthy Kids and Vt Dept of Ed offers annual School Wellness Awards program, recognizing schools for their efforts implementing wellness policies related to physical activity, physical education and nutrition. In 2009 approximately 20 schools applied, in 2010 15 schools applied. All schools won an award.
4.Fit and Healthy Vermonters staff is an active member on the Vt DOT Safe Routes to Schools advisory committee. Over 30 communities have Safe Routes to Schools programs that promote community involvement in supporting safe walking and biking to school.
5. Worksite wellness workgroup developed wellness resources: policies, environmental changes for obesity prevention and breastfeeding promotion. Over 70 worksites participated in trainings on implementation.

c. Plan for the Coming Year

Continue to maintain and support the activities above through grants funding to communities, resource development, and training.

The Fit and Healthy Vermonters program is developing a statewide planning and zoning project to support increased physical activity. Tools and training will support community partners in working with their local town planning and zoning officials. The goal is to integrate supports for health into town plans, and ordinances.

State Performance Measure 7: *The percent of children with SSI who receive an annual care plan.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13	14	14	15
Annual Indicator	12.6	12.3	11.2	9.0	8.8
Numerator	193	203	177	150	148
Denominator	1537	1644	1585	1666	1685
Data Source				VT Medicaid Claims data	VT Medicaid Claims data
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	15	15	

Notes - 2009
Medicaid claims data used for this measure is from Federal fiscal year 2009.

Notes - 2008
Medicaid claims data used for this measure is from Federal fiscal year 2008.

Notes - 2007
The data for 2006 were updated to reflect more complete information.

a. Last Year's Accomplishments
We continued to identify families who might be eligible for SSI and/or Katie Beckett/TEFRA medicaid and assisted them with their applications. Most often these were newly diagnosed children in Child Development Clinic, and for them, Medicaid and SSI were a major gateway to supports such as personal care assistance and diapers, not available any other way.

We continued to annotate in our database whether an enrolled child has SSI.

Although PCPs can bill medicaid for care plans, their contracts with other payers are a barrier to doing so, even for children who do not have private insurance. The contracts would require them to bill all families for care plans, with non medicaid families incurring an out of pocket cost. This situation is a confounding problem.
In addition, only children with a certain form of medicaid (PC Plus) have reimbursable care plans as a benefit. Therefore, the methodology of counting paid plans is likely a drastic undercount of actual plans.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to assist families with SSI an Katie Beckett applications to increase eligibility; expand collaboration with Division of Developmental Services in this effort.		X		X
2. Continue to annotate CSHN enrollment database with SSI eligibility.				X
3. Utilize NFI grant to pilot (in consultation with the AAP) an outreach to new SSI families about the Medical Home and their PCP's ability to document care plans.		X		X
4. Raise issue of payment barriers, in the VT health care reform process		X		X
5. Collaborate with other programs requiring plans, to include PCP in process.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As above.
We realize that there are many other programs which utilize care plans as a required element. Efforts to engage PCPs in those care plans (and engage the plans with PCPs) would also address the need...although not necessarily the need for reimbursement.

c. Plan for the Coming Year

Continue to identify children who may qualify for SSI and Katie Beckett and assist their families with applications

Continue to annotate SSI status in CSHN database.

Work with AAP, through NFI grant, to identify children with SSI in medical homes.

Raise the issue of barriers to billing medicaid for a service not covered by commercial insurances, in the forum of VT health care reform.

Promote medical home inclusion in other processes involving care plans (e.g., Part C; Bridges; Unified Services Plan; Hi-Tech; etc)

State Performance Measure 8: *The percent of low income children (with Medicaid) who utilize dental services in a year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52	52	54	54	55
Annual Indicator	49.1	49.2	52.9	50.0	52.8
Numerator	36413	36376	30321	29584	33322
Denominator	74140	73886	57307	59170	63141
Data Source				CMS-416 report	CMS-416 report
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	

Notes - 2009
Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 and 2008 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 46.2%; 2003 = 46.8%; 2004 = 46.4%; 2005 = 49.2%; and 2006 = 52.3%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

Notes - 2008
Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 and 2008 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 46.2%; 2003 = 46.8%; 2004 = 46.4%; 2005 = 49.2%; and 2006 = 52.3%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

Notes - 2007
Source of data reported in previous years was Office of Vermont Health Access (OVHA). 2007 data were revised in 2010 to reflect published CMS-416 reports. Comparable values for: 2002 = 46.2%; 2003 = 46.8%; 2004 = 46.4%; 2005 = 49.2%; and 2006 = 52.3%. Data from 2007 onwards should not be compared directly with previously published values for earlier years.

a. Last Year's Accomplishments
1. WIC screen and referral for Oral Health Services.
2. Continue to administer and expand Tooth Tutor programs as capacity allows.
3. Continue to monitor, via the school health emergency card, the number of children reporting they do not have a dental home and school nurses assist with finding dental home.
4. Follow up to the statewide Oral Health Plan and Dental Dozen.

5. Loan/scholarships for dental health professionals administered via Office of Rural Health.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with Dental community and Medicaid to implement new pediatric periodicity schedule.	X	X	X	X
2. Head Start Tooth Tutors train dental office staff to see children ages 0-3	X	X		
3. Expand Tooth Tutor as capacity allows.		X		
4. Continue VDH district communications statewide to followup on oral health plan an Dental Dozen.			X	X
5. Pilot to place dental hygienists in four district offices.		X	X	
6. Pilot to place dental hygienists in large pediatric offices.		X		
7. Train pediatricians and family practice physicians to perform oral health assessments on infants and toddlers.			X	X
8. EPSDT and school nurse monitor/follow up with children who report not having access to dental home.	X	X		
9. FQHC services offering clinical dental services.	X	X		
10. Loans and scholarships for dental health workforce development.			X	X

b. Current Activities

Activities as listed above and also the folowing:
1. Placement of a dental hygienist in one of the state's largest pediatric practices to evaluate the oral health needs of children, ages 0-3 who use Medicaid insurance - assess and referral to participating area dentists and also to train providers on oral health risk assessment.
2. Development of 12 strategies from the Oral Health Plan and building capacity through staffing and funding.
3. Continue planning for dental hygienists to be placed in four VDH district offices - pilot project to do case management of children needing a medical home.
4. Data on dental home from school health emergency card is able to be organized and retrieved electronically.
5. Vt Dental Periodicity Schedule created in conjunction with recommendations of American Academy of Pediatric Dentistry. Posted on VDH website.
7.Opening of a dental clinic in the Morrisville area FQHC.
8. Presented a Tooth Tutor training and conference in conjunction with Vt Dental Hygienists' Assn Annual Meeting.
9. Provided daylong training in Baby Oral Health Project in collaboration with Vermont' Head Start programs and the AAPD's Dental Home Inititiative.

c. Plan for the Coming Year

Activities as listed above and also the following:
1. Continue planning and implementation of Dental Dozen initiative.
2. Work with Medicaid/AAP partners to promote the reimbursement to PCPs to apply varnish for children
ages 3-5.
3. Planning continues to expand program to placement of Dental Hygeinist in pediatric practices and in up to 4 VDH district offices.
4. Coordinate with Medicaid and dental providers to implement dental periodicity schedule.

5. Enhance the ability of Tooth Tutor to track individuals over time to ensure that the families make and keep appointments at least annually.
6. Target the few remaining non-participating schools that are eligible for the School-Based Fluoride Mouthrinse Program.
7. Head Start Tooth Tutors will train dental office staff to see children ages 0-3; at least 10 offices will be targeted.

State Performance Measure 9: *The percent of children with emotional, developmental, or behavioral problems that require treatment or counseling who received needed mental health services in the past year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		72	72	73	74
Annual Indicator	70.0	70.0	69.3	69.3	69.3
Numerator	7956	7956	8438	8438	8438
Denominator	11371	11371	12172	12172	12172
Data Source				National Survey Children's Health, CAHMI website	National Survey Children's Health, CAHMI website
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	

Notes - 2009
The most recent NSCH survey was carried out in 2007. The estimate for 2009 is based on data collected in 2007.

Notes - 2008
These data are derived from a NSCH survey that was carried out in 2007. The estimate for 2008 is data collected in the previous year. Provisional 2007 data have been revised accordingly to reflect the most recent survey data.

Notes - 2007
These data were revised to reflect information collected in the most recent NSCH survey carried out in 2007.

a. Last Year's Accomplishments
1. Fostering Healthy Families public health nurse coordinates with local child welfare office staff to complete the Health Intake Questionnaire on all children who enter state child custody system - assists the state child custody system to ensure that the child receives needed medical and behavioral health care.
2. Continued support to the integration of early childhood childhood services (Family Infant, Toddler, Children's UPstream Services, Healthy Babies, Kids and Families)
3. Dept of Mental Health (DMH) provides and monitors the use of Medicaid Waiver funds for plans with intensive and personalized services and supports to enable children and adolescents to recieve needed mental health treatment in their home or community and to avoid psychiatric hospitalization.
4. DMH providing support and oversight of children admitted to to psychiatric hospitalization to

ensure that discharge planning takes place.
5. DMH is part of the interagency Case Review Committee (CRC) for children being considered for
residential treatment placement for mental health needs. The CRC ensures that each child's needs are met in the least restrictive environment appropriate, the proposed placement offers the needed care, and the child's treatment team actively prepares for the child's return.
6. VDH, DMH, Fletcher Allen Health Care, the Office of Vermont Health Access, and the state's network of community mental health centers (CMHCs) worked together to identify the variety of services available and to assure coordination between the different entities so that mental health services reach children and their families effectively at the community level.
7. CMHCs provided core capacity services to 9,600 children and adolescents. Services fall into 4 categories: (1) prevention, early intervention, and community consultation; (2) supports; (3) clinical treatment in outreach and clinic settings; and (4) immediate response, acute care, and access to intensive residential treatment.
8. DMH continued p[lanning and implementation of methods to integrate mentalhealth services to children and their families into the world of physical health care, especially in primary and pediatric care practices.
9. DMH applied for and was awarded a federal 6 yr, $9 million grant to further develop the state's interagency services and supports to adolescents and young adults (ages 16-21)
10. DMH and private, non-profit Center for Health and Learning applied for and received 3 yr, $1.5 million Youth Suicide Prevention Grant from SAMHSA. Grant objective is to form a diverse and broad-based coalition to plan and assure implementation of methods to equip youth and adults with the knowledge, attitude, skills, and resources to prevent and respond to suicidal behavior.
11. DMH sponsored ARC project to improve CMHC treatment of children and adolescents with complex psychological trauma. One contract provides training and TA to a team of clinical staff from each CMHC to increase skills in assessment and treatment.
12. DMH convened and led a public/private workgroup of providers and stakeholders to assess the situation around the treatment of the state's children and adolescents with psychotropic medications for their mental health needs.
13. DMH began a pilot program to use a standardized assessment tool (Child Behavior Checklist or CBCL) as part of a child's or adolescent's initial assessment and the tracking of results by the CMHC. The CBCL in its various reporter and age-related forms is the basis of the Achenbach System of Empirically Based materials. These materials are researched, developed, and produced primarily at the Research Center for Children, Youth, and Families, Inc., a nonprofit scientific and educational corporation located at the University of Vermont in Burlington, Vermont.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Positive Behavioral Supports in schools	X	X		
2. Community care coordination via CUPS.		X		
3. VDH/VCHIP create depression screening tool for use by PCP for screening youth for depression.	X	X		
4. VDH role in oversight to systems of community mental health organizations to assure capacity, quality, and discharge planning.		X	X	X
5. Child tele-psychiatry pilots in community health centers.			X	
6. UVM child psychiatry fellowship. in 2010, fellows begin training rotations at CSHN Child Development Clinic, to gain experience in the care of the child with developmental disabilities affecting behavior and mental health.	X			
7. Medical home for adolescents when transitioning to adult life.	X	X	X	X

8. Co-location of mental health services.	X			
9. Increased access to mental health services.	X	X		
10. Expand ASEBA pilo sites	X	X		

b. Current Activities

Activities as listed above and the following:

1. DMH/VDH contracts for psychiatric consultation by University Pediatrics and UVM's Child Psychiatry faculty to Berlin Family Health and Essex Pediatrics to provide child psychiatric consultation to primary care providers via on site consultation, via fax/email, and telephone/face-to-face.
2. DMH contracts for psychiatric consultation from Otter Creek Associates to provide training and technical assistance to primary care providers to improve their ability to screen, diagnose, refer Medicaid eligible children.
3. DMH encourages through 2 pilot site projects, the co-location of CMHC clinical staff at family/pediatric medical practice and at a small rural medical center.
4. DMH implement ARC contract with CMHC .
5. DMH continues work with Psychotropic Medications workgroup to implement the group's five recommendations.
6. DMH working to finalize minimum standards for Behavioral Interventionists in Success Beyond 6, a school-based mental health program.
7. DMH and Center for Health and Learning coalition to focus on prevention of youth suicide - begin training curriculum for school personnel on this 1st year of 3 year grant.
8. DMH and partners in State Interagency Team working with Local Interagency Teams to submit plans to improve services to teens transitioning to adult life.
9. DMH has expanded ASEBA to 2 CMHC in Vt.
10. Fostering Healthy Families nurses lessened capacity due to staff reductions.

c. Plan for the Coming Year

Activities as listed above and the following:

1. VDH, DMH, and SA will continue work to develop a medical home for adolescents transitioning to adult life.
2. DMH and its interagency partners in the State Interagency Team (SIT) will review regional plans submitted through the YIT and move forward on more detailed planning, implementation, and evaluation monitoring and TA.
3. DMH will re-convene the Psychotropic Medications Workgroup to review progress on their recommendations.
4. DMH and the Center for Health and Learning will continue to develop the work of the coalition under the Youth Suicide Prevention Grant.
5. DMH will strive to further expand the ASEBA pilot sites.
6. DMH will continue to promote the use of the ARC model to treat children and adolescents who have complex psychological trauma and their families.
7. DMH will work with the Department of Education, Local Education Agencies, and CMHCs to implement Positive Behavior Supports (PBS) in schools. Successful implementation should reverse the unsustainable growth in expressed need for intensive 1:1 Behavior Interventionist (BI) services to students by enhancing school climate and supports to school staff and all students. Concomitantly, DMH will adopt new Minimum Standards for BI services offered by CMHCs under Success Beyond Six and begin reporting outcome data at the state level.
8. Planning for reduced Fostering Healthy Families services because of reductions in state public health nursing staff.

State Performance Measure 10: *The percent of one year old children who are screened for blood lead poisoning.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		80	82	82	83
Annual Indicator	75.1	77.5	84.6	78.6	79.6
Numerator	5119	5209	5249	5287	5349
Denominator	6818	6721	6203	6723	6723
Data Source				Lead sreening Program	Lead sreening Program
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84	85	90	90	

Notes - 2009
In 2008, the Vermont Child Lead Screening program changed the method used to calculate the numerator for this measure. Previous calculations were found to have undercounted the number of children screened. The rate for 2008 and 2009 should not be compared directly to previously published rates for the earlier years. Comparable rate calculations for 2005 through 2006 are 77.2% and 79.3%, respectively. The 2009 rate is based on the population estimate for 2008, and should be considered provisional.

Notes - 2008
In 2008, the Vermont Child Lead Screening program changed the method used to calculate the numerator for this measure. Previous calculations were found to have undercounted the number of children screened. Comparable rate calculations for 2005 through 2007 are 77.2%, 79.3% and 84.6%, respectively. The rate for 2008 should not be compared directly to previously published rates for the earlier years.

Notes - 2007
The apparent 'spike' in screening rates in 2007 may be, in large part, an artifact due to a lower than expected 2007 population estimate for VT 1 year olds, published by the Census Bureau. The increase in rates was not due to a larger number of children screened in the numerater, but rather was due to a smaller population estimate in the denominator.

The 2007 rate has been revised in 2009. Previous calculations were found to have undercounted the number of children screened. Comparable rate calculations for 2005 through 2006 are 77.2% and 79.3% respectively. The rate for 2007 should not be compared directly to previously published rates for the earlier years.

a. Last Year's Accomplishments
1. Ongoing program to assess and offer lead screening in WIC clinics

2. Instruction and logistical support for performing lead screening availalble to primary care practices and clinics.

3. Collaborations with housing authorities to perform lead abatement at identified homes.

4. Postcards routinely mailed to parents of 10 and 20 month old children reminding them of need for lead screening at their medical home.

5. Public media campaign on the dangers of childhood lead poisoning: health fairs, Welcome Baby bags, postering, attendance at home shows, etc.

6. Collaboration with specific communities of Burlington and Bellows Falls for activities.

7. Postcard reminders to 9,000 rental property owners about compliance with Vermont's lead law.

8. Provide education to Legislators for crafting of Lead legislation dealing with essential maintenance practices, safe housing, lead in comsumer products, child screening requirements, etc.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess and offer lead screening services at WIC clinics.	X	X		
2. VDH to offer instruction and logistical support for lead screening to primary care providers and FQHC.		X	X	
3. Collaboration with housing authorities to perform lead abatement at identified buildings.			X	
4. Increase surveillance system capacity so as to capture all lead screening and testing results into one data systems.				X
5. Geocoding system to identify high risk communities,			X	X
6. Postcard mailing to parents of 10 and 20 month olds reminding of need of r lead screening.		X		
7. Postcard mailings to rental property owners about compliance with Vermont's lead maintenance and housing laws.		X		X
8. Community grants.			X	
9. Public media awareness activities.		X		
10. Implementation of VDH-related aspects of recently passed lead legislation.	X	X	X	X

b. Current Activities
Activities from last year in addition to the following resulting from a strategic planning process:

1. Geocoding system to identify high risk communities.

2. Developing electronic system to allow rental landlords and facilities mangers, etc to file compliance statements electronically.

3. Implementing education programs on essential maintenance practices trainings at construction-related courses in high schools and colleges.

c. Plan for the Coming Year
Actions as described for current activities in order to continue with aggressive approach to implementing the Lead Strategic Plan and the 2008 Lead legislation. Continued support of physicians so as to be able to achieve goals of 2008 Lead Legislation by voluntary screening: Goal of 85% of one year olds screened and 75% of two year olds screened by January 2010.

E. Health Status Indicators

Introduction
See also narrative discussion for each indicator. See Section IIIF HSCI and Section IIIA State

Overview. SSDI data support and analyses will be a major support for the planned MCH strategic planning in 2007-2008 and the 2010 Strengths and Needs Assessment.

Note: The MCH Surveillance Quarterly Report is based on preliminary vital records data from the twelve months previous to the publication date -- includes entry into prenatal care, low birthweight, teen births and pregnancies, and infant mortality -- modified after new birth certificate 7/06 with new data elements such as weight gain and smoking.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.2	6.9	6.2	7.0	7.0
Numerator	399	446	403	444	444
Denominator	6467	6510	6510	6338	6338
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Vital Records birth data for 2009 were not available at the time of submission. They should be available early in 2011. The 2009 estimate is based on 2008 data.

Narrative:
The low birthweight rate has been increasing in Vermont since the early 1990's, however the increase has been found primarily in the moderately low birthweight category. It is essential that policymakers have a longer-term perspective of changes in key indicators. Thus, in addition to the on-going quarterly reports, VDH is preparing(with SSDI support) an annual report to monitor trends in key MCH indicators. This new report system is envisioned to include various measures, including Title V national and state performance measures, health outcome measures, health status indicators and health systems capacity indicators. /2010/ VCHIP project to assist birth hospitals with adoption of evidenced based protocols regarding elective inductions and Caesarean deliveries //2010///2011/VCHIP training on late preterm births for VDH district office staff and birth hospital staff conducted statewide//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.8	5.1	4.7	5.2	5.2
Numerator	300	325	292	319	319
Denominator	6277	6315	6279	6116	6116
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Vital records birth data for 2009 were not available at the time of submission. They should be available in early 2011. The 2009 estimate is based on 2008 data.

Narrative:
Please see related discussion for Health Status Indicator 01A.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.1	1.4	1.0	1.1	1.1
Numerator	74	91	66	68	68
Denominator	6467	6510	6510	6338	6338
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Vital Records birth data for 2009 were not available at the time of submission. They should be available in early 2011. The 2009 estimate is based on 2008 data.

Narrative:
Please see related discussion Health Status Indicator 01A.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.8	1.0	0.8	0.8	0.8
Numerator	48	65	49	51	51
Denominator	6277	6315	6279	6116	6116
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Vital Records birth data for 2009 were not available at the time of submission. They should be available in early 2011. The 2009 estimate is based on 2008 data.

Narrative:
Please see discussion Health Status Indicator 01A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	7.8	8.2	5.4	5.4
Numerator	26	25	26	17	17
Denominator	326670	321183	316900	313994	313994
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Vital Records death data and population estimates for 2009 were not available at the time of submission. They should both be available in early 2011. The 2009 estimate is based on 2008 data.

Notes - 2008
There were 7 VT non-intentional deaths in 2008 amongst children 0-14. A 3-year moving average (2006-2008) was applied to both numerator and denominator.

Notes - 2007
There were 4 VT non-intentional deaths in 2007 amongst children 0-14. A 3-year moving average (2005-2007) was applied to both numerator and denominator.

Narrative:
An SSDI analysis of hospital data was conducted during 2006. Data was analyzed by 5-year age groups examining changes in utilization rates and reasons for inpatient hospitalizations over 10 yrs. Also, SSDI analysis of the 2003 Emergency Department data, the first complete year of ED data. The 2004-2008 ED data will be available for future analysis to monitor changes over time in the number/rate of visits and reasons for the visits. Many VDH staff and statewide partners are involved in monitoring data and trends for infant and child unintentional deaths. The Child Fatality Review Committee performs a thorough review of all child deaths from unnatural causes, especially those due to child abuse, drug overdose, injuries, motor vehicles, and SUDI. The VDH's Injury Prevention Program's Advisory Committee is also a key partner in monitoring trends and responding to the unique issues that affect Vermont's child death rates. For example, a state wide symposium was held in July, 2006 to assess the issue of death and injury associated with young teen drivers. /2008/ VDH providing data support to the Child Fatality Review Committee for the Committee's preparation of a status report on child deaths for the years 1995-2005.//2008// /2009/Report released Spring 2008.//

The Vermont Injury Prevention Program's infrastructure is based on the State and Territorial

Injury Prevention Directors Association's (STIPDA) Safe States five component public health approach to injury prevention. The first component is directed at determining the burden of injury and developing a plan of action -- planning for this component is happening at present. The draft list of categories of injuries that have been identified in the Vermont Injury Surveillance Plan (in congruence with CDC grant requirements) are as follows: suicides, falls, motor vehicle injuries, poisoning, firearm-related injuries, homicides, TBI, drowning, and fire-related injuries. /2010/ Work continues on analysis of farm related injuries and fatalities - data will be used by Farm Health Task Force, Title V Strengths and Needs Assessment, Injury Prevention Program. Injury analysis and planning support by Children's Safety Network. In June 2008 the Vt Injury Prevention Burden Document was finalized with data ready to inform the creation of the Vermnt State Injury Prevention Plan which is to be completed by December 2009. October 2009 scheduled statewide symposium on Childhood Injury Prevention. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator					
Numerator					
Denominator	326670	106110	104674	103210	103210
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Vital Records death data and population estimates for 2009 were not available at the time of submission. They should be available in early 2011. 2008 data remain provisional. The 2009 estimate is based on 2008 data.

Notes - 2008
In 2008 there were 2 deaths amongst 0-14 year olds due to MVA. Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using small samples, a three year avarage (2006, 2007 and 2008) = 2.5 was calculated that is still less than 5 events. The rate should therefore not be calculated.

Notes - 2007
In 2007 there were 3 deaths. Following the procedures outlined in Technical Note IX, Guidelines for Calculating Performance Measures using small samples, a three year avarage (2005, 2006 and 2007) = 3.7 was calculated that is still less than 5 events. A rate should therefore not be calculated.

Narrative:
Vermont injury data demonstrate that motor vehicle crashes among teens and young drivers are the number one injury for this age group. An SSDI-supported analysis also reported that between 1994 and 2003, 105 children aged 0-14 were injured in nontraffic motor vehicle accidents in Vermont, averaging almost 47% of those injured in traffic accidents. In 2003, as many children

were injured in nontraffic crashes as those injured in traffic crashes. More than half of these injuries occurred to the driver, and almost two thirds involved off-road vehicles. Among youths 15-24, there were 156 nontraffic crash injuries, which averaged almost 12% of the traffic crash injuries. In this ten year period, there were 41 deaths among children from motor vehicle crashes, and 213 deaths among youths 15-24. Few of these deaths occurred in nontraffic crashes, three among children and one among youths driving off road. Traffic crashes killed 38 children and 212 youths in that same time period. In addition, it was found that a total of 16 children were injured in snowmobile crashes between 1994-2003, which represented 6.2% of the total snowmobile accidents. There were crash injuries to 60 youths aged 15-24, which was almost one quarter of all snowmobile crash injuries.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	27.5	22.4	23.5	20.4	20.4
Numerator	25	20	63	54	54
Denominator	91002	89301	268200	264597	264597
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Vital Records death data and population estimates for 2009 were not available at the time of submission. They should be available in early 2011. 2008 data remain provisional. The 2009 estimate is based on 2008 data.

Notes - 2008
There were 18 deaths from MVA amongst VT youths 15-24 years old in 2008. Since the numerator was less than 20, a three year average of 2006, 2007 and 2008 is reported.

Notes - 2007
The rate for 2007 was revised upwards to 18 in 2010 based on late reports of out-of-state death records for 2 VT residents. Since the numerator was less that 20, a 3 year average based on 2005, 2006 and 2007 is reported.

Narrative:
Child Fatality Review Team has conducted specific discussions about the issue of underage drinking and relation to risky teen driving behavior. VDH Alcohol and Drug Abuse programs oversee several initiatives with schools and state police to educate teens and the public about risks of under-age drinking and teen driving.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Indicator	180.0	174.3	162.4	161.8	161.8
Numerator	191	185	170	167	167
Denominator	106116	106110	104674	103210	103210
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Neither Hospital Discharge data nor population estimates for 2009 were available at the time of submission. These should be available in early 2011. The 2009 estimate is based on 2008 data.

Notes - 2008
Consistent with previous years, data are derived from Hospital Discharge dataset (source: VT Banking, Insurance, Securities and Health Care Administration) discharges from inpatient hospital setting. Since only a minority of injuries result in inpatient admissions, it is estimated that the numerator represents less than 2% of total injuries reported.

Notes - 2007
Consistent with previous years, data are derived from Hospital Discharge dataset (source: VT Banking, Insurance, Securities and Health Care Administration) discharges from inpatient hospital setting. Since only a minority of injuries result in inpatient admissions, it is estimated that the numerator represents less than 2% of total injuries reported.

Narrative:
/2008/ Regarding the analyses for HSI 4, the data for all nonfatal injuries for children ages 14 and younger reflect a rate of 176/100,000 as taken from the hospital discharge data from inpatient stays. This data reflects the number of injury events, not the actual number of children injured. However, because this number reflects only inpatient stays, it accounts for less than 2% of all unintentional injuries in this age group of 0-14 years. In 2005, a total of 14,791 injuries to children aged 0-14 years were seen in hospital related clinical systems (emergency rooms, outpatient clinics, and inpatient admission) for treatment of unintentional injuries. Of these injuries, 441 were related to motor vehicle crashes and 244 were due to non-traffic motor vehicle events. Considering inpatient stays for the age group of 15-24 years, the rate is 166/100,000. In 2005, a total of 18,198 youths aged 15-24 were seen in hospital-related clinical systems for treatment of unintentional injuries. Of these injuries, 2,181 were related to motor vehicle crashes and 412 were due to non traffic motor vehicle crashes. Thus, a rate for all unintentional injuries for the 0-14 age group is 13,938/100,000 and for the 15-24 age group is 19,997/100/000. //2008// See also HSI 03A.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	19.8	18.1	15.8	12.4	12.4
Numerator	21	58	50	39	39

Denominator	106116	321183	316900	313994	313994
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Neither Hospital Discharge data nor population estimates for 2009 were available at the time of submission. They should be available in early 2011. The 2009 estimate is based on 2008 data.

Notes - 2008
In 2008, there were 10 reports of injuries due to motor vehicle accidents amongst VT children 0-14 years old. A three year average (2006-2008) was therefore applied.

Consistent with previous years, data are derived from Hospital Discharge dataset (source: VT Banking, Insurance, Securities and Health Care Administration) discharges from inpatient hospital setting. Since only a minority of injuries result in inpatient admissions, it is estimated that the numerator represents less than 2% of total injuries reported.

Notes - 2007
In 2007, there were 12 reports of injuries due to motor vehicle accidents amongst VT children 0-14 years old. A three year average (2005-2007) was therefore applied.

Consistent with previous years, data are derived from Hospital Discharge dataset (source: VT Banking, Insurance, Securities and Health Care Administration) discharges from inpatient hospital setting. Since only a minority of injuries result in inpatient admissions, it is estimated that the numerator represents less than 2% of total injuries reported.

Narrative:
See discussion Health Status Indicator 03 and 04A.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	127.5	140.0	92.2	121.3	121.3
Numerator	116	125	81	106	106
Denominator	91002	89301	87897	87399	87399
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Neither Hospital Discharge data nor population estimates for 2009 were available at the time of submission. They should be available in early 2011. The 2009 estimate is based on 2008 data.

Notes - 2008
Consistent with previous years, data are derived from Hospital Discharge dataset (source: VT Banking, Insurance, Securities and Health Care Administration) discharges from inpatient hospital setting. Since only a minority of injuries result in inpatient admissions, it is estimated that the numerator represents less than 2% of total injuries reported.

Notes - 2007
Consistent with previous years, data are derived from Hospital Discharge dataset (source: VT Banking, Insurance, Securities and Health Care Administration) discharges from inpatient hospital setting. Since only a minority of injuries result in inpatient admissions, it is estimated that the numerator represents less than 2% of total injuries reported.

Narrative:
See discussion Health Status Indicator 04A

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	12.2	14.7	13.3	14.7	14.7
Numerator	271	330	297	326	326
Denominator	22209	22507	22331	22160	22160
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data to complete this item are currently unavailable. Population estimates for 2009 will be available at the end of CY2010. The 2009 estimate is based on 2008 data.

Narrative:
Data on Chlamydia and other sexually transmitted diseases are collected and analyzed from laboratory reports to the VDH. The Sexually Transmitted Disease Program within the Division of Health Surveillance monitors prevalence of these diseases and collaborates with state and community organizations such as Planned Parenthood, American Red Cross, Department of Education and many local groups to direct efforts at prevention, screening and treatment.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.3	5.5	5.1	5.8	5.8

Numerator	451	560	508	568	568
Denominator	104813	102295	100084	98719	98719
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data to complete this item are currently unavailable. Population estimates for 2009 will be available at the end of CY2010. The 2009 estimate is based on 2008 data.

Narrative:
Data on Chlamydia and other sexually transmitted diseases are collected and analyzed from laboratory reports to the VDH. The Sexually Transmitted Disease Program within the Division of Health Surveillance monitors prevalence of these diseases and collaborates with state and community organizations such as Planned Parenthood, American Red Cross, Department of Education and many local groups to direct efforts at prevention, screening and treatment.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	6588	6278	164	29	117	0	0	0
Children 1 through 4	26047	24820	647	117	463	0	0	0
Children 5 through 9	33517	31909	875	136	597	0	0	0
Children 10 through 14	37058	35526	716	200	616	0	0	0
Children 15 through 19	45231	43676	784	260	511	0	0	0
Children 20 through 24	42168	40741	558	202	667	0	0	0
Children 0 through 24	190609	182950	3744	944	2971	0	0	0

Notes - 2011
Data from state population estimate contains a pooled number for Asian plus Native Hawaiian or Other Pacific Islander, reported here under Asian. The number of Vermont residents claiming Native Hawaiian or Other Pacific Islander race is however likely to be very small.

Data from state population estimate contains a pooled number for Asian plus Native Hawaiian or Other Pacific Islander, reported here under Asian. The number of Vermont residents claiming Native Hawaiian or Other Pacific Islander race is however likely to be very small.

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Data from state population estimate contains a pooled number for Asian plus Native Hawaiian or Other Pacific Islander, reported here under Asian. The number of Vermont residents claiming Native Hawaiian or Other Pacific Islander race is however likely to be very small.

Narrative:
See discussions on programs for children and families, such as WIC, CIS coordination, and home visiting in Sections IIIA, IIIB, and NPM/SPM.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	6442	146	0
Children 1 through 4	25471	576	0
Children 5 through 9	32784	733	0
Children 10 through 14	36330	728	0
Children 15 through 19	44302	929	0
Children 20 through 24	41357	811	0
Children 0 through 24	186686	3923	0

Notes - 2011

Narrative:
See discussions on programs for children and families such as WIC, CIS coordination, and home visiting in Sections IIIA, IIIB, and NPM/SPM.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	6	5	1	0	0	0	0	0
Women 15	93	85	3	1	0	0	0	4

through 17								
Women 18 through 19	379	364	5	0	0	0	0	10
Women 20 through 34	4882	4627	59	5	24	1	0	166
Women 35 or older	981	934	9	1	8	0	0	29
Women of all ages	6341	6015	77	7	32	1	0	209

Notes - 2011

Narrative:
See discussions on programs for women such as WIC, familiy planning, and home visiting in Sections IIIA, IIIB, and NPM/SPM.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	6	0	0
Women 15 through 17	90	3	0
Women 18 through 19	375	4	0
Women 20 through 34	4827	55	0
Women 35 or older	973	8	0
Women of all ages	6271	70	0

Notes - 2011

Narrative:
See discussions on programs for women such as WIC, family planning, and home visiting in Sections IIIA, IIIB, and NPM/SPM.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	29	27	1	0	0	0	0	1
Children 1 through 4	5	5	0	0	0	0	0	0
Children 5 through 9	3	3	0	0	0	0	0	0

Children 10 through 14	6	6	0	0	0	0	0	0
Children 15 through 19	28	24	3	0	0	0	0	1
Children 20 through 24	31	31	0	0	0	0	0	0
Children 0 through 24	102	96	4	0	0	0	0	2

Notes - 2011

Narrative:
See discussions on overall programs for children, especially those such as Child Fatality Review Team (Section IIIE), SUDI program (IVF), Injury Prevention (Sec IIIA) and NPM 10,16, 17.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	29	0	0
Children 1 through 4	5	0	0
Children 5 through 9	3	0	0
Children 10 through 14	6	0	0
Children 15 through 19	27	0	1
Children 20 through 24	31	0	0
Children 0 through 24	101	0	1

Notes - 2011

Narrative:
See discussions on overall programs for children, especially those such as Child Fatality Review Team (Section IIIE), SUDI program (IVF), Injury Prevention (Sec IIIA) and NPM 10,16, 17.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	148441	142209	3186	742	2304	0	0	0	2008
Percent in household headed by	32.0	0.0	0.0	0.0	0.0	0.0	0.0	32.0	2007

single parent									
Percent in TANF (Grant) families	4.7	0.0	0.0	0.0	0.0	0.0	0.0	4.7	2007
Number enrolled in Medicaid	62708	35302	1076	73	295	0	0	25962	2009
Number enrolled in SCHIP	3547	760	4	0	8	0	0	2775	2009
Number living in foster home care	1309	0	0	0	0	0	0	1309	2009
Number enrolled in food stamp program	31241	0	0	0	0	0	0	31241	2009
Number enrolled in WIC	16398	14747	389	29	133	28	480	592	2009
Rate (per 100,000) of juvenile crime arrests	1041.0	0.0	0.0	0.0	0.0	0.0	0.0	1041.0	2007
Percentage of high school drop-outs (grade 9 through 12)	2.9	0.0	0.0	0.0	0.0	0.0	0.0	2.9	2009

Notes - 2011

Narrative:
See general discussions on health and social programs for infants and children and youth in narrative and Performance Measures.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	145329	3112	0	2008
Percent in household headed by single parent	0.0	0.0	32.0	2007
Percent in TANF (Grant) families	0.0	0.0	4.7	2007
Number enrolled in Medicaid	36746	267	25695	2009
Number enrolled in SCHIP	772	4	2771	2009
Number living in foster home care	0	0	1309	2009
Number enrolled in food stamp program	0	0	31241	2009
Number enrolled in WIC	15642	164	592	2009
Rate (per 100,000) of juvenile	0.0	0.0	1014.0	2007

crime arrests				
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	2.9	2009

Notes - 2011

Narrative:
See general discussion on health and social programs for infants and children and youth in narrative and Performance Measures.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	40620
Living in urban areas	66104
Living in rural areas	81419
Living in frontier areas	0
Total - all children 0 through 19	147523

Notes - 2011
2008 State urban/rural population estimate was based on the U.S. Census Bureau 2000 Census, Summary File 1, matrix P12. Updated data should be available in 2011 based on the 2010 decentennial census. Note: available data were for children 0-17 years only (not 0-19, as defined). The total for children living in urban areas is the sum of children living in metropolitan plus non-metropolitan urban areas, as defined by the U.S. Census Bureau.

Narrative:
See State Overview discussion Section IIIA. Collaboration with Region 1 MCHB and CDC-funded Injury Programs is facilitated by Childrens Safety Network (Newton, MA) Establishing system of regular conference call and face-to-face meetings along with Offices of Rural Health. One result of this newly established "conversation" is a specific discussion on working definitions of "rural/urban" to assist injury data analysis and allow for consistency within New England for data gathering and comparability.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	610260.0
Percent Below: 50% of poverty	3.1
100% of poverty	9.0
200% of poverty	27.9

Notes - 2011
Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Narrative:
See State Overview discussion Section IIIA and general discussions of state health and social programs.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	143696.0
Percent Below: 50% of poverty	4.0
100% of poverty	10.0
200% of poverty	31.6

Notes - 2011
Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Data from U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Narrative:
See State Overview discussion Section IIIA and general discussions of state health and social programs.

F. Other Program Activities

Refugee Program: VDH assists local medical homes to conduct health evaluations for newly arriving refugees. The Refugee Health Coordinator, the State Coordinator, and the District Office staff work closely with the Vermont Refugee Resettlement Program and other community-based organizations to assure that critical health services are both available and culturally appropriate. Goals of the refugee health program: health outreach for refugees, technical support for providers, surveillance for infectious diseases.

Sudden Unexplained Death in Infancy (SUDI) Goals to reduce the impact of unexpected infant death via public education about infant care practices and assure system of care for families that provides compassionate investigation and grief services. Procedures and protocols for VDH public health nurses updated and distributed to DOs. Safe sleep environment pamphlet for parents is being distributed to medical practices and child care providers. IN 2007, Vt Medical Examiner's Office held two statewide trainings for health care professionals and first responders about sudden infant death events and best practice procedures for death scene investigation. In 2009, SUDI response protocols and family ed materials emphasizing safe sleep environment updated by collaboration between OLH/MCH and Injury Prevention. SUDI presentation by Vt CME at Oct 2009 Childhood Injury Prevention Conference.

Office of Minority Health (OMH) supports VDH strategies to address disease prevention, health service delivery and applied research for minority and health disparate populations. Past activities: development of the Alcohol and Drug Abuse Program's Rite of Passage Initiative, the implementation of a DHHS-OMH grant to address disparities in cancer, diabetes, and heart disease within the Lao and American Indian communities through the strengthening of intergenerational relationships, and address tobacco cessation and prevention program activities within the minority and GLBTQ populations. The VOMH is a member of the Interpreter Task Force that coordinates training opportunities for Vermont non-English language interpreters and translators. In 2007, OMH coordinated with local health coalitions on health issues affecting the families of migrant Mexican farm workers. Goals of OMH strategic plan 1) Building infrastructure 2) Data quality, collection, reporting 3) Cultural competency training 4) Community development and leadership. 2010 Disparities report completed.

State Incentive Cooperative Agreement (New Directions): One of five states funded via the National Youth Substance Abuse Initiative. The goal is to reduce use of alcohol, tobacco, marijuana and other drugs by teens (aged 12-17) through a network of community based activities. See Section IIIB and SPM 3.

The Office of Rural and Primary Care receives funds from the HRSA Bureau of Health Professions and the Office of Rural Health Policy to improve access to health services for underserved populations. This is done through planning, technical assistance, grants, coordination and advocacy. Activities: the development and administration of medical and dental loan repayment programs, grants to community organizations for services and/or infrastructure development, training and technical assistance to community based health care organizations, assessment of the need for health services in communities, workforce coverage analysis and trends, and application for Federal designations of underservice and program grants to the statewide AHEC and Free Clinics. The Steering Committee is composed of a broad range of provider groups concerned with access to care: Medicaid program, Mental Health Department, Department of Aging, Hospital Association, Medical Society, Primary Care Association, Dental Society and Area Health Education Center. Recent projects are the development of a set of criteria to identify Vermont communities at high medical need in order to seek Governor Designations of underservice and expand the opportunities for participation in the Federally Qualified Health Centers programs and reassessment of the State Loan Repayment Program for primary care providers. Nursing loan repayment enacted by state legislature. Primary Care Loan Repayment Program updated in 2002. Working with the Medicaid Office, Dept of Mental Health and the Office of Alcohol and Drug Abuse programs to examine policy, programming and funding to support the integration of behavioral health and primary care. In 2003, the Office received a grant from the RWJ Foundation to increase access to oral health services for Medicaid eligibles: develop reimbursement strategies to improve access to dental care, expand school based oral health programs, provide consumer prevention education and enhance oral health provider recruitment and retention. Other projects: Nurse faculty loan repayment program, FQHC Look Alike development, migrant farm worker health and health access assessment, statewide healthcare workforce development planning.

AHS Domestic Violence Initiative and Domestic Violence Advisory Groups (DVAG) includes VDH, Dept of Corrections, Dept for Children and Families, Department of Disabilities, Aging and Independent Living, Injury Prevention, and Medicaid. VDH DVAG goals: VDH programs responsive to domestic violence victims, increase awareness among VDH staff of domestic violence as a public health issue, and to develop an agenda within VDH for the primary prevention of domestic violence. In 2009, S.112 and S.357 passes, strengthening penalties for domestic violence and assistance for victims. Domestic Violence Fatality Review Commission issues annual report.

Comprehensive Obstetrical Services Program: Administered by OB/GYN, Fletcher Allen Health Care, Burlington, provides comprehensive, team based, maternity care to women who are socially/economically at-risk. The care coordination team includes an obstetrician, a social worker, a nurse and a nutritionist. Services include comprehensive prenatal care, lab and genetic testing, birth and postpartum services, enrollment in WIC, breastfeeding support, and contraception counseling. Service coordination also happens with the NICU and the intensive services for women who have chemical addictions.

G. Technical Assistance

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1705272	1694536	1694662		1694662	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	2599926	1585399	2668350		2180046	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	1520096		1066452	
7. Subtotal	4305198	3279935	5883108		4941160	
8. Other Federal Funds *(Line10, Form 2)*	17765122	17743694	18923531		17743694	
9. Total *(Line11, Form 2)*	22070320	21023629	24806639		22684854	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	40325	29086	31308		7794	
b. Infants < 1 year old	167703	120263	133134		114372	
c. Children 1 to 22 years old	1705448	1546961	2534711		1763389	
d. Children with	2318043	1518802	3054306		1919653	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	73679	64823	129649		69500	
g. SUBTOTAL	4305198	3279935	5883108		3874708	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		83554	
c. CISS	0		105000		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	115000		130000		130000	
g. WIC	13222524		14445768		13500000	
h. AIDS	1449501		1449501		1400000	
i. CDC	1956555		1741720		1700000	
j. Education	175000		175000		100000	
k. Other						
Family Planning	751898		781898		830140	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	2107182	1037412	3099138		1203442	
II. Enabling Services	1255612	1473306	1592498		1697895	
III. Population-Based Services	554680	185717	305147		240754	
IV. Infrastructure Building Services	387724	583500	886325		732617	
V. Federal-State Title V Block Grant Partnership Total	4305198	3279935	5883108		3874708	

A. Expenditures

Expenditure trends. The following factors have had, or are likely to have, an impact on MCH-related expenditures:

Reductions: The State of Vermont reduced the number of classified positions at the beginning of SFY2010. These reductions affected almost all departments in the State. In the Health Department, these reductions affected almost all programs. Most Title V services are provided through Children with Special Health Needs (CSHN), and almost all other Title V services are provided by staff in 12 district offices. Both CSHN and the district offices experienced staff reductions. As of this writing, there are no additional staff reductions anticipated for FY11. The FY11 State budget assumes that there will be reductions in grant and contract expenditures, although no specific targets related to MCH have yet been identified. We do not know how much these changes will affect MCH expenditures.

Reorganization: The Vermont Agency of Human Services transferred Vermont's Mental Health

programs into the Health Department in 2004. Then, effective July 1, 2007, the Mental Health programs were removed form the Health Department and a new Department of Mental Health was created. The new Mental Health Department continued to share business office functions, IT support and physical space within the Health Department. Most recently, the two departments separated their business office and other support services. None of the Mental Health expenditures are included in this report for FY09 or FY11. "Other federal funds" does not include Mental Health funding.

Expenditure documentation: Vermont began using its current accounting system in FY02. The system is named "VISION," which is an acronym for "Vermont Integrated Solution for Information and Organizational Needs". The accounting package includes the Financial and Distribution modules contained within PeopleSoft's software suite for Education and Government (E&G) version 7.5. It is designed to be an integrated financial and management tool. While most transactions are entered into VISION directly, payroll information is currently run on a separate system and summary payroll data are extracted from the Human Resource Management System (HRMS) and uploaded into VISION. The HRMS software is also a PeopleSoft product and is compatible with VISION. Upgrades to both VISION and HRMS will be implemented in tandem. The VISION system was implemented with as few Vermont-specific characteristics as possible so that future upgrades could be accepted with relatively minimal retrofitting work. VISION contains a number of modules that allow for a variety of functions, such as asset management, as well as expenditure tracking.

The Vermont Health Department can provide assurance that we have established "such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting" [Sec 502(a)(3)].

Cost Allocation: The Vermont Health Department operates under a Cost Allocation Plan approved by the DHHS Division of Cost Allocation. This Plan determines how we will collect certain overhead costs into cost pools and how those overhead cost pools will be allocated to the various programs and funding sources, including the Maternal and Child Health Block Grant. Because we have an approved Cost Allocation Plan, Vermont does not have an indirect rate agreement, which would be the alternate method for charging overhead costs to programs. Cost Allocation Plans--instead of indirect rate agreements--are relatively rare among Health Departments. Basically, the approved methods collect general overhead costs on a quarterly basis into cost pools at the division level and also at the Department-wide level. Allowable charges from the Statewide cost pool are also determined. These three overhead cost pools (division, department and statewide) are then allocated to all of the programs in the department (including state funded programs as well as federally funded programs). The allocation process is based on the relative direct salary costs of each program in the quarter.

In addition to the distribution of the three cost pools listed above, for the purposes of reporting our expenditures for the Maternal and Child Health Block Grant, the overhead costs of the Children with Special Health Needs unit are also distributed to the direct programs provided by that division. The distribution of these costs is based on the relative direct salary costs of CSHN staff in each of its programs in the quarter. Although CSHN is not designated as a "division" of the Health Department, it seems to be most equitable to distribute these costs in a manner that mimics the distribution of divisional overhead costs. This results in a fairer picture of the true cost of each of the individual clinics and programs operated by CSHN.

The current Plan was initially approved by DHHS Division of Cost Allocation on February 28, 2006. The Vermont Agency of Human Services continues to work with Public Consulting Group, Inc., of Boston, on on-going revisions to this plan. Revisions to the plan are submitted to DHHS Division of Cost Allocation quarterly, and are approved by DHHS quarterly.

Single State Audit. The State Auditor of Accounts arranges for an annual audit in compliance with the Single Audit Act, as well as in conformity with Section 506(a)(1) of the Maternal and Child

Health Block Grant. The audit is performed by KPMG under contract with the Vermont Auditor of Accounts. Although the Maternal and Child Health Block Grant does not qualify as a "major" program for audit purposes, transactions may be tested as part of a general review of management control. There were no findings related to expenditures funded by the Maternal and Child Health Block Grant in FY 2009 or prior years. The audit report can be found on the State Auditor's website at http://auditor.vermont.gov.

B. Budget

Consolidated Budget: In Vermont, the Department's budget includes both State funds and all if the federal funds available to the Department. Because it is a consolidated budget--rather than a budget that appropriates only the General Fund--the budget for maternal and child health services already includes federal funds and state General and Special funds in a complementary package of resources.

Independent Compliance review: The Vermont Health Department tracks its expenditures attributable to the Maternal and Child Health Block Grant. Prior to drawing funds or filing financial status reports, however, the data is independently reviewed by the Agency of Human Services (AHS). Cash draws are performed by AHS rather than the Health Department. As part of their review of the financial data, AHS also reviews compliance with certain of the grant financial requirements, specifically including the maintenance of effort requirement and the non-federal match requirement. The quarterly calculations of the allowable claim by AHS, like the calculations of the Health Department, deducts one quarter's share of the maintenance of effort amount from our allowable charges prior to determining the cash draw for the quarter. AHS also determines that the needed non-federal share is available for each quarter. Once each quarter, AHS and the Health Department formally review the allowable federal claim after making adjustment for these factors. In this way, AHS assures that the Health Department has an independent review of our claims for federal funds.

30%-30% Requirement: The Health Department calculates the amount expended on each category. For FFY 2009, 45% of expenditures was made in Component B and 50% was made for Children with Special Health Care Needs.

Administration costs: Administrative costs are defined in the same terms that they were defined in 1989: administrative costs are the extra-departmental costs that are allocated to the Health Department and to the programs within the Health Department. These costs are that component of the allocated costs that are attributable to the support services of payroll, buildings, etc. The definition of "administration" costs does not include costs such as the policy direction activities of the Health Commissioner, etc. The administrative costs of the Maternal and Child Health Block Grant can be readily determined by analysis of the allocated costs, and these costs are tracked on a quarterly basis to ensure that there is no increase in the costs that would exceed the allowable maximum. Administrative costs for FFY2009 were 1.8% of total costs.

Maintenance of effort: [Sec. 505(a)(4)] The maintenance of effort amount for Vermont, based on the amount of unmatched State expenditures reported in 1989, is $167,093. We deduct one quarter of the maintenance of effort amount from our allowable claims each quarter rather than annually. Quarterly reductions of our allowable costs are more consistent with federal cash management directives than an end-of-year adjustment.

Special projects: [Sec.505(a)(5)(C)(i)] There is continuation funding for the Vermont Regional Perinatal Program, which was a special project that was funded by Title V prior to 1981. The funding for the program is $52,656.

Consolidated health programs: [Sec. 505(a)(5)(B)] Funds are used to support certain programs

that were initiated under the provisions of the consolidated health programs, as defined in Section 501(b)(1). MCH Block Grant funds are used to support the Regional Genetics Program, which was initiated under a section 1101 grant prior to 1981, and is referred to as a consolidated health program in Sec 501(b)(1)(C). The Regional Genetics grant is $140,056. State General Funds are used to support the adolescent pregnancy program at the Addison County Parent Child Center, which was initiated under a Title VI grant prior to 1981, and is referred to as a consolidated health program in Sec. 501(b)(1)(D). The Addison County Parent Child Center grant is $32,820.

Other Federal funds: The other Federal funds used to support MCH-related goals are listed in Form 2 and 4. There is no significant change in the type or total amounts of other Federal funds. As noted above, this has not been changed to include Mental Health expenditures.

Source of State matching funds: The State match consists entirely of cash payments of State General funds or State Special funds (e.g., tobacco settlement funds, foundation grants, etc). The State match is exclusively from non-federal funds. These non-federal funds are appropriated as described above and the use of these non-federal funds is monitored by the Agency of Human Services as well as the Health Department, as noted above.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.